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No. 07-652

Supreme Court, U.S.
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In The
Supreme Court of the United States

UNITED SENIORS ASSOCIATION, INC.,
AS A PRIVATE ATTORNEY GENERAL,

Petitioner,

v.

PHILIP MORRIS USA, R.J. REYNOLDS TOBACCO COMPANY, BROWN & WILLIAMSON TOBACCO CORPORATION, INDIVIDUALLY AND AS THE SUCCESSOR TO THE AMERICAN TOBACCO COMPANY, LORILLARD TOBACCO COMPANY, AND LIGGETT GROUP, INC.,

Respondents.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The First Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

The Medicare as Secondary Payer ("MSP") statute, 42 U.S.C. §1395y(b)(2) and (3), prohibits Medicare from paying for the medical expenses of Medicare beneficiaries where another source of payment, such as the insurance of a tortfeasor who injured a beneficiary or the group health plan established by a beneficiary's employer, is responsible to pay. In most cases, Medicare will pay a beneficiary's medical costs conditionally, and then seek reimbursement from such a "primary plan" when it is identified. To enforce Medicare's right to be reimbursed, the MSP authorizes the government to sue to recover Medicare's expenditures. Similarly, the statute establishes a private action to recover that money. The question presented is:

Whether the MSP's private action provision gives standing to any person as a "private attorney general" to bring a *qui tam* action on behalf of Medicare to recover Medicare expenditures from the responsible primary payer.

CORPORATE DISCLOSURE

Petitioner, plaintiff-appellant below, is the United Seniors Association, Inc., which has no parent company and, as an entity operating under 26 U.S.C. §501(c)(4), has not issued shares or debt security to the public.

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PETITION FOR A WRIT OF CERTIORARI

Petitioner, United Seniors Association, Inc. ("United Seniors") respectfully requests that a writ of certiorari issue to review the judgment of the United States Court of Appeals for the First Circuit in this case.

OPINIONS BELOW

The opinion of the court of appeals (Pet.App. 1a-17a) is reported at *United Seniors Ass'n, Inc. v. Philip Morris USA*, 500 F.3d 19 (1st Cir. 2007). The memorandum and order of the district court (Pet.App. 18a-28a) is not reported, but can be found at *United Seniors Ass'n, Inc. v. Philip Morris USA*, 2006 WL 2471977 (D.Mass. 2006).

JURISDICTION

The judgment of the court of appeals was entered on August 20, 2007. The jurisdiction of this Court is invoked under 28 U.S.C. §1254.

STATUTE AND REGULATION INVOLVED

The Medicare as Secondary Payer ("MSP") statute, 42 U.S.C. §1395y(b), is reproduced at Pet.App. 29a-40a. Pertinent provisions of regulations of the

Centers for Medicare and Medicaid Services ("CMS") are reproduced at Pet.App. 41a-52a.

STATEMENT OF THE CASE

The decision below is now the lead opinion among over 50 lower-court cases that radically depart from this Court's precedents concerning standing in *qui tam* cases.[1] The court of appeals held that the MSP private cause of action, 42 U.S.C. §1395y(b)(3)(A), is not a *qui tam* provision. Yet over at least 60 years, this Court has rejected precisely the kind of narrow, formulaic construction of *qui tam* provisions employed to reach this result. *See United States ex rel. Marcus v. Hess,* 317 U.S. 537, 540-42 (1943); *Cook County v. United States ex rel. Chandler,* 538 U.S. 119, 130-33 (2003).

[1] *See, e.g., Stalley v. Catholic Health Initiatives*, 458 F.Supp.2d 958 (E.D.Ark. 2006), *appeal filed*, No. 06-3884 (8th Cir. Nov. 15, 2006); *Brockovich v. Vanguard Healthcare*, No. 06-CV-547, 2006 WL 4484171 (C.D.Cal. Oct. 24, 2006), *appeal filed*, No. 06-56690 (9th Cir. Dec. 1, 2006); *In re Medtronic, Inc. Implantable Defibrillator Prod. Liab. Litig.*, No. 05-MDL-1726 (D.Minn. Jan. 8, 2007), *appeal filed sub nom. Stubbiefield v. Medtronic, Inc.*, No. 07-1374 (8th Cir. Feb. 2, 2007); *Stalley v. Orlando Reg'l Healthcare Sys., Inc.*, No. 06-CV-1824, 2007 WL 1841290 (M.D.Fla. Jan. 22, 2007), *appeal filed*, No. 07-10768 (11th Cir. Feb. 16, 2007); *Stalley v. Erlanger Health Sys.*, No. 06-CV-0194, 2007 WL 672301 (E.D.Tenn. Feb. 28, 2007), *appeal filed*, No. 07-5358 (6th Cir. Mar. 23, 2007); *Stalley v. Genesis Healthcare Corp.*, No. 06-CV-2492, 2007 WL 781907 (E.D.Pa. Mar. 12, 2007), *appeal filed*, No. 07-2070 (3d Cir. Apr. 30, 2007).

The MSP private action seeks to mobilize citizens to secure reimbursement of Medicare for the expenses it paid, but should have been paid by another insurer. In this case, the insurers who should have paid are various self-insured tobacco companies – tortfeasors who have injured Medicare beneficiaries, causing the American taxpayers, through Medicare, to pay for the medical care required by those injuries, for which those companies should have been the primary payers. §1395y(b)(2)(A)(ii). By any measure, the cost to the taxpayers from defendants' tort has been staggering: estimated at upwards of $10 billion per year.[2] And the Medicare expenditures at stake in the other MSP cases active below are similarly great. In the

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[2] *See, e.g.*, Xiulan Zhang *et al.*, *Cost of Smoking to the Medicare Program, 1993* 20 Health Care Fin. Rev. 179 (1999) (In 1993, "smoking accounted for 9.4 percent of Medicare expenditures – $14.2 billion."); National Center on Addiction and Substance Abuse, THE COST OF SUBSTANCE ABUSE TO AMERICA'S HEALTH SYSTEM, 4, 6 (1994) (estimating that "for 1994, substance abuse-related Medicare hospital costs will rise to $20 billion," of which more than 80% was for "smoking-related medical conditions"). *See also* Centers for Disease Control, *Annual Smoking – Attributable Mortality, Years of Potential Life Lost, and Economic Costs – United States, 1995-1999,* 51 MORBIDITY AND MORTALITY WEEKLY REPORT 300-303 (April 12, 2002) (estimating annual personal medical expenditures attributable to smoking as $75.5 billion, approximately 8 percent of total personal medical expenditures); W. Max, *The Financial Impact of Smoking on Health-related Costs: A Review of the Literature,* 15 AMERICAN JOURNAL OF HEALTH PROMOTION 321-33 (2001) (estimates of annual personal medical expenditures attributable to smoking range from about 6 to about 9 percent of total personal medical expenditures).

MSP cases brought against hospitals and nursing homes, for example, it has been estimated that the burden on Medicare from the negligent treatment of seniors has reached approximately $9 billion per year.[3]

Moreover, this case marks another critical point of conflict in the continuing "conversation" between Congress and the courts concerning MSP. Millions of Americans depend on – and pay for – Medicare. Since 1980, Congress has consistently acted on its concern for the financial vulnerability of Medicare by expanding the scope of MSP and strengthening its enforcement, only to be frustrated by judicial resistance. Congress has then had to step in to correct narrow judicial constructions of MSP, as it did most recently with the MSP clarification contained in the 2003 Medicare legislation. *See* MEDICARE PRESCRIPTION DRUG, IMPROVEMENT, AND MODERNIZATION ACT OF 2003, §301, 117 Stat. 2066 ("MMA"). With the decision below, it is once again apparent, regrettably, that the lower federal courts are not listening.

In concept and purpose – seeking "to right an economic wrong done to the government" – MSP's *qui tam* provision is identical to the *qui tam* provision of the False Claims Act ("FCA"), 31 U.S.C. §§3729-3733, which was significantly amended in 1986, the same year the *qui tam* provision was added to MSP.

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[3] *See, e.g.*, HealthGrades, Inc., Third Annual Patient Safety in American Hospitals Study 2 (2006).

Manning v. Utilities Mutual Ins. Co., 254 F.3d 387, 394 (2d Cir. 2001). However, contrary to the lower courts' view, there is no one correct model for the drafting of a *qui tam* provision. The FCA is one approach, but as this Court itself has recognized, many other varieties of *qui tam* provisions populate American legal history, most far simpler than the FCA. *See Vermont Agency of Natural Resources v. United States ex rel. Stevens*, 529 U.S. 765, 768 n.1, 776-77 nn.5-7 (2000). *See also Marcus*, 317 U.S. at 541 n.4 (noting that statutes that simply provide a reward to informers impliedly authorize a *qui tam* action).

The court of appeals, echoing dozens of other lower court rulings addressing the standing of MSP plaintiffs, takes the precise structure of the FCA's *qui tam* as the measure of what must be in a genuine *qui tam* statute, and finds the MSP approach wanting. Most examples of universally-recognized *qui tam* statutes enacted from the First Congress on would not pass muster under such a standard. The court of appeals mistakes the different approach of MSP for silence on what it believes to be key elements of *qui tam*. In contrast to the FCA, which happens to have all relevant provisions for *qui tam* spelled out in one part of the statute in relative proximity to one another, MSP has some elements in one part of the statute, others elsewhere, and others in regulations. This is appropriate to, and a product of, MSP's different setting – a *qui tam* mechanism designed for, and written into, a specific federal spending program run

by its own dedicated subcabinet agency, the Centers for Medicare and Medicaid Services ("CMS").[4] That is a far different context, and contemplates different operational needs, than the FCA's *qui tam,* which was originally written in 1863, before the explosion of the federal bureaucracy, to apply to all military procurement, and then expanded in 1986 to cover all federal procurement, regardless which component of the federal government was spending the money.

The court of appeals has thus ruled that the MSP private action is not a *qui tam* at all, and that only a "Medicare beneficiary who received unreimbursed Medicare payments for treatment of smoking-related injuries" can use it. Pet.App. 9a. These rulings are both illogical and contrary to this Court's precedents. First, it is obviously incorrect to say that an injured Medicare beneficiary whose medical care has been paid by Medicare alone has standing to bring an MSP private action. A Medicare beneficiary is never "unreimbursed" as the court of appeals posited – the money at issue was not spent by him (and compensation for his personal injuries is not within the scope of MSP). Contrary to the court of appeals' representation, Pet.App. 8a-9a, its holding is at odds with this Court's understanding of injury-in-fact, *see Lujan v. Defenders of Wildlife,* 504 U.S. 555, 560-61 (1992); a Medicare beneficiary is no more injured with respect to the

[4] CMS was formerly known as the Health Care Financing Administration ("HCFA"). Depending on their date, authorities cited here may refer to the agency by its old name, HCFA.

economic wrong remedied by MSP than is the plaintiff here.

Second, the court of appeals' antagonism to *qui tam* – manifested by the catalog of "explicit" provisions it finds lacking in MSP, Pet.App. 11a-13a – is profoundly at odds with this Court's unequivocal rejection of any such "interpretive approach" of "utmost strictness" toward *qui tam* provisions. *Marcus*, 317 U.S. at 540-41. In contrast, the Second and the Eleventh Circuits have implicitly determined, without seeming difficulty, that the MSP private action is a *qui tam* statute that provides standing to a bounty-hunter seeking to help Medicare secure reimbursement for medical expenses necessitated by torts injuring Medicare beneficiaries. *Manning*, 254 F.3d at 394 ("Both the FCA and MSP allow for a multiplier of damages to enable the government to recover its funds while also providing a financial incentive for private citizens to bring such suits. . . . Both statutes thus create 'private attorneys general' by authorizing private citizens to receive part of the recovery."); *Glover v. Liggett Group, Inc.*, 459 F.3d 1304, 1307 (11th Cir. 2006) ("The MSP also creates a private right of action with double recovery to encourage private parties who are aware of non-payment by primary plans to bring actions to enforce Medicare's rights.").

With over 50 district courts echoing the First Circuit's reasoning, it appears unlikely that any other Circuit will explicitly hold that entities like the plaintiff do have standing under MSP. This case

therefore presents a timely and worthy vehicle to settle the lower courts' quarrel with this Court's *qui tam* jurisprudence, and to restore Congress' regime to stem the enrichment of other insurers at the expense of the businesses and individuals whose taxes fund Medicare.

A. MSP – Legislation and Litigation

1. Congress in the 1980s created MSP through a series of amendments to Medicare "designed to curb skyrocketing health costs and preserve the fiscal integrity of the Medicare system." *Fanning v. United States,* 345 F.3d 386, 388 (3d Cir. 2003). As the House Budget Committee put the problem, "Medicare has served to relieve private insurers of [their] obligations to pay the costs of medical care." H.R. REP. NO. 96-1167, at 389 (1980), *reprinted in* 1980 U.S.C.C.A.N. 5526, 5752. Adapting common-sense principles from the private insurance world, MSP prevents Medicare from paying for medical expenses another insurer is responsible to cover.[5] MSP makes Medicare the "secondary" rather than the "primary" payer for its insureds in two general contexts, reflecting how the other payer's responsibility to pay legally arises.

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[5] MSP "is essentially the same concept known in the private insurance industry as coordination of benefits, and refers to those situations where Medicare does not have primary responsibility for paying the medical expenses of a Medicare beneficiary." 63 Fed.Reg. 26,810 (May 14, 1998).

First, with regard to health insurance, Medicare is secondary when an employer has voluntarily assumed the responsibility to pay an employed Medicare beneficiary's medical bills under a group health plan. §1395y(b)(2)(A)(i). Second, with regard to various forms of liability insurance, Medicare is secondary when that responsibility to pay is imposed on another party by operation of law, such as under a workers' compensation scheme, no-fault insurance, automobile insurance, or liability insurance (including a self-insured plan) when a Medicare beneficiary is the victim of a tort. §1395y(b)(2)(A)(ii).

This case arises under the second of these two categories, specifically under Congress' command that Medicare make no payment "to the extent that . . . payment has been made or can reasonably be expected to be made under . . . [a] liability insurance policy or plan (including a self-insured plan)." *Id.* Thus MSP makes the cost of treating an injured Medicare beneficiary fall first on the liability insurance of the tortfeasor who caused the injury (or on the tortfeasor itself if uninsured). *See* STAFF OF SENATE COMM. ON THE BUDGET, 96TH CONG., RECONCILIATION (S. 2885) AND SPECIAL RULES FOR ITS CONSIDERATION 92 (Comm. Print 1980).

So as not to burden beneficiaries, "Medicare does make conditional payments for covered services, even when another source may be obligated to pay, if that other source is not expected to pay promptly." *Cochran v. HCFA*, 291 F.3d 775, 777 (11th Cir. 2002); §1395y(b)(2)(B)(i). The condition on the payment is

reimbursement to Medicare "if it is demonstrated that [a] primary plan has or had a responsibility to make payment with respect to such item or service." §1395y(b)(2)(B)(ii).

2a. Given this commitment to "pay and chase," enforcing Medicare's right to reimbursement has been a continuing challenge. "When Medicare pays . . . it is paying 'in the dark' – it does not know, and *cannot* know, whether someone else will pay. . . . HHS and Congress have repeatedly flagged Medicare's inability to ascertain the existence of alternative sources of coverage as a weakness in the secondary payer program." *United States v. Baxter Int'l, Inc.*, 345 F.3d 866, 901 & n.30 (11th Cir. 2003) (emphasis in original). MSP enforcement is further complicated by the fact that Medicare's interest is not identical to that of its beneficiary, and a beneficiary cannot be relied upon to pursue Medicare's money. After all, the taxpayers, not the beneficiary, paid for the beneficiary's medical expenses. A beneficiary might have many reasons, not the least limited resources, not to pursue the party responsible to pay.

Until 1984, MSP had no express enforcement mechanism. Regulations, however, filled that gap, providing that, "[i]f the beneficiary did not pursue the claim, HCFA could institute its own action against the insurer or the person responsible for the injury. In its discretion, HCFA could require a beneficiary . . . to authorize HCFA to pursue the beneficiary's rights if the beneficiary fails to do so." 47 Fed.Reg. 21,103, 21,105 (May 17, 1982) (proposing 42 C.F.R. §405.324).

Beginning in 1984, Congress stepped in, and since then "has repeatedly clarified and augmented the Government's powers to recoup conditional Medicare payments from primary sources." *Baxter,* 345 F.3d at 877. In that year, Congress amended MSP to subrogate explicitly the Government to a Medicare beneficiary's rights to recover medical expenses from another insurer (up to the amount paid by Medicare) and to create a direct right of action for the government to sue that liability insurer or self-insurer. DEFICIT REDUCTION ACT OF 1984, Pub.L. No. 98-369, §2344, 98 Stat. 464, 1095 (*codified at* 42 U.S.C. §§1395y(b)(2)(B)(iii) (direct action) & (iv) (subrogation)) ("DEFRA").

Both of these provisions were essential to effective MSP enforcement. Under MSP, "when the defendant is a liability insurer the claim will be founded upon tort law and the tort in question will be the one allegedly committed by the insured against the Medicare beneficiary." *In re Dow Corning Corp.,* 250 B.R. 298, 342 (Bankr.E.D.Mich. 2000).[6] Since the insurer's "responsibility to pay" under MSP thus "flows entirely from its obligations to the Medicare beneficiary," *id.* at 346, MSP's subrogation provision allows Medicare to go after its money based on those obligations to its beneficiary. *See also Cochran,* 291 F.3d at 777 ("[P]rimary payers include the beneficiary's

[6] MSP also covers self-insurers, where the "insurer" and the "insured" are the same entity. *See* §1395y(b)(2)(A)(ii).

private insurer and the private insurer of someone liable to the beneficiary.").

However, without more, MSP's goal of recovering Medicare's dollars from insurers and self-insurers would be frustrated by the "widely retained common law rule barring direct tort actions against liability insurers until after judgment is obtained against their insured tortfeasors." *United States v. Farm Bureau Ins. Co.,* 527 F.2d 564, 566 (8th Cir. 1976), cited in *Dow,* 250 B.R. at 342. MSP's direct action expressly "affords the Government with a direct right of action against the insurer that would not otherwise be available under the law." *Dow,* 250 B.R. at 344. *See also Rosa v. Allstate Ins. Co.,* 981 F.2d 669, 672 (2d Cir. 1992) (A direct action statute is "designed to eliminate the necessity of two lawsuits: the first in which the victim sued the insured, and the second in which – if the victim prevailed on the merits – the insured would seek indemnity from his insurer.").

Finally, Congress made it clear that Medicare could sue not just the responsible insurer, but also *any* party that had received payment from that insurer for the medical expense at issue and had not reimbursed Medicare. DEFRA, §2344(b) (*now codified at* 42 U.S.C. §1395y(b)(2)(B)(iii)). *See also* 42 C.F.R. §411.22(a) ("[A]n entity that receives payment from a primary payer must reimburse CMS."); §411.24(g) ("CMS has a right of action to recover its payments from any entity, including a beneficiary, provider, supplier, physician, attorney, State agency or private insurer that has received a primary payment.").

2b. Two years later, Congress further enhanced MSP enforcement by adding the private cause of action pursuant to which this case was brought. OMNIBUS BUDGET RECONCILIATION ACT OF 1986, Pub.L. No. 99-509, §9319(b), 100 Stat. 1874, 2011 (*codified at* 42 U.S.C. §1395y(b)(3)(A)). In adding the private cause of action, Congress did not start from scratch, or create some free-standing mini-code, but built onto the MSP edifice it had already constructed with a straightforward provision: "There is established a private cause of action for damages (which shall be in an amount double the amount otherwise provided) in the case of a primary plan which fails to provide for primary payment (or appropriate reimbursement) in accordance with paragraphs (1) and (2)(A) [the basic secondary-payer rules]." §1395y(b)(3)(A).[7]

If a private MSP plaintiff is successful and fully recovers double damages from a primary payer, Medicare is entitled to be fully reimbursed for its expenditures, as described above, and the private plaintiff retains the remainder. The amount due to Medicare is adjusted based on the cost of procuring the judgment. 42 C.F.R. §411.37(a) & (c). If the recovery is less than the amount of Medicare payments, Medicare is entitled to the full amount recovered, less procurement costs. §411.37(d). However, CMS may compromise and waive full recovery. §§401.613, 411.28.

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[7] CMS may intervene in the private MSP action. 42 C.F.R. §411.26(b).

3a. While, as CMS has observed, "Congress intended that the MSP provisions be construed to make Medicare a secondary payer to the maximum extent possible," 71 Fed.Reg. 9,466, 9,467 (Feb. 24, 2006), many courts have resisted. CMS went on to explain:

> The Congress . . . became aware that various parties were pressing several interpretations of the MSP provisions that would, if ultimately accepted, severely limit the applicability of the MSP provisions at considerable expense to the Medicare program. Many of these interpretations were presented in the context of Federal court litigation over the meaning of various MSP provisions. The Congress rejected these attempts to incorrectly limit the application and scope of the MSP statute.

Id.

In 1994, for example, the D.C. Circuit held that Medicare could not recover under MSP from the third-party administrator of a group health plan. *Health Ins. Ass'n of America, Inc. v. Shalala*, 23 F.3d 412, 417 (D.C. Cir. 1994). Congress responded by amending MSP to expressly provide for such a recovery. BALANCED BUDGET ACT OF 1997, Pub.L. No. 105-33, §4633(a), 111 Stat. 251, 487 (*codified at* 42 U.S.C. §1395y(b)(2)(B)(ii)).

Most recently, in its 2003 Medicare legislation, Congress responded to several judicial misinterpretations narrowing MSP. Courts had held that a settlement agreement without an admission of liability

could not create a responsibility to reimburse Medicare,[8] and that, to be a "self-insured plan" under MSP, an entity could not simply be uninsured, but must set aside funds to cover its tort risk and establish formal procedures to pay claims.[9] In response, Congress clarified MSP to the effect that Medicare is entitled to be reimbursed from a settlement and that any uninsured business entity is "self-insured" for MSP purposes. MMA, §§301(b)(2)(A) & (b)(1), 117 Stat. 2066, 2222 (*codified at* 42 U.S.C. §1395y(b)(2)(B)(ii) (b)(2)(A)(ii)). *See Brown v. Thompson,* 374 F.3d 253, 261 (4th Cir. 2004) (a "welcome" clarification).

3b. The 2003 clarification provided the impetus for the filing of three groups of cases addressing mass torts injuring Medicare beneficiaries. First, two cases were brought against tobacco companies to recover Medicare's expenditures for the treatment of smoking-attributable diseases. *Glover,* 459 F.3d 1304, was brought against two companies for such Medicare expenditures in Florida. The Eleventh Circuit in

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[8] *Thompson v. Goetzmann,* 337 F.3d 489, 492, 493 (5th Cir. 2003); *In re Diet Drugs Prod. Liab. Litig.,* 2001 WL 283163, at *2 (E.D.Pa. 2001); *Dow,* 250 B.R. at 341.

[9] *Mason v. The American Tobacco Co.,* 346 F.3d 36, 41 (2d Cir. 2003); *Goetzmann,* 337 F.3d at 498-99. *See also United States v. Philip Morris,* 156 F.Supp.2d 1, 6 (D.D.C. 2001); *In re: Orthopedic Bone Screw Prod. Liab. Litig.,* 202 F.R.D. 154, 166 (E.D.Pa. 2001), *rev'd on other grounds sub nom. Fanning v. United States,* 346 F.3d 386 (3d Cir. 2003); *Diet Drugs,* 2001 WL 283163, at *10-11; *Dow Corning,* 250 B.R. at 338 n.24. *But see Baxter,* 345 F.3d at 898 (holding that no "set-aside of the funds and formal procedures" were required to be a self-insured plan).

Glover affirmed 12(b)(6) dismissal of the case on the ground that a prior judgment or settlement establishing a responsibility to pay medical expenses was needed before an MSP case could be brought.

The case at bar was the other MSP tobacco case, brought by the United Seniors Association, "a non-profit, non-partisan, taxpayer protection organization with a nationwide network of over 1.5 million men and women," Pet.App. 59a, against all the major tobacco companies for Medicare's expenditures outside of Florida for smoking-attributable illnesses.

Second, over 50 private MSP actions have been brought to recover Medicare's expenditures for the injuries inflicted by the negligence of nursing homes and hospitals on the seniors in their care. Nearly all have been dismissed for lack of standing on the ground that the MSP private action is not a *qui tam* provision, using the FCA as the standard as the court of appeals did here. *See, e.g., Stalley,* 458 F.Supp.2d at 962-63. Some have also been dismissed on the alternative ground of *Glover* that an MSP suit cannot be brought until after a responsibility to pay has been established. *See, e.g., id.* at 964.

The final group was brought against medical device manufacturers to recover Medicare's expenditures for allegedly defective devices and for their removal and replacement. Here, too, courts have found that the MSP private action is not a *qui tam* suit for failure to copy the FCA model, while alternatively adopting the *Glover* "two-lawsuit" rule. *See,*

e.g., In re Guidant Corp. Implantable Defibrillators Prod. Liab. Litig., 484 F.Supp.2d 973, 979-81 & n.3 (D.Minn. 2007).

3c. The final case that completes the relevant litigation background is the Government's case against the major tobacco companies advancing various claims, including MSP and RICO. In 2001 (before the 2003 clarification), the Government's MSP claim was dismissed on the now-congressionally-overruled ground that the defendants, though uninsured, were not "self-insured" under MSP. *Philip Morris*, 156 F.Supp.2d at 6. The Government's efforts then focused on their RICO claim, and, after a nine-month bench trial last year the district court issued a massive ruling against the defendants. *United States v. Philip Morris USA, Inc.*, 449 F.Supp.2d 1 (D.D.C. 2006). That ruling included detailed factual findings that effectively establish the tort alleged by the plaintiff here – a battery, the concealed exposure to the addictive properties of nicotine. *Id.* at 168, 209-10, 214-19, 271, 289, 308-11, 337-38, 374, 852, 856, 858-59, 897-900.

B. The Decisions Below

1. United Seniors filed this suit as an MSP private action under 42 U.S.C. §1395y(b)(3)(A) and 28 U.S.C. §1331. Pet.App. 53a, 59a. United Seniors alleged that the defendants are self-insured plans under MSP and had a responsibility to pay for the medical expenditures caused by certain smoking-attributable diseases

because they intentionally, but clandestinely, exposed Medicare beneficiaries to addictive nicotine, which they deliberately manipulated to enhance its impact on smokers and "hook" their customers. Pet.App. 55a, 75a-76a, 86a-87a. Such concealed exposure to a toxic material is a classic intentional tort, battery. *See* RESTATEMENT (SECOND) OF TORTS §18(1), §892B cmt. e, illus. 5; W. PROSSER, HANDBOOK ON THE LAW OF TORTS §§9, 18 (4th ed. 1971). This action seeks reimbursement of Medicare's expenditures for smoking-attributable diseases, outside of Florida, from 1999 to the present. Pet.App. 53a.

The district court granted defendants' motion to dismiss on August 28, 2006, expressly adopting the *Glover* holding that "an alleged tortfeasor's responsibility for payment of a Medicare beneficiary's medical costs must be demonstrated *before* an MSP private cause of action for failure to reimburse Medicare can correctly be brought." Pet.App. 26a. The district court did not set out any analysis of the actual MSP text to explain this result. Instead, it simply stated that "[a]ny contrary interpretation" would run afoul of several policy concerns articulated by the Eleventh Circuit. Pet.App. 26a-28a. The court tersely added that it was "[r]elying on the jurisprudential grounds and statutory reasoning expounded . . . in *Glover*." Pet.App. 28a. Though the defendants had challenged plaintiff's standing, Pet.App. 20a, the district court did not address that claim.

2. The court of appeals affirmed dismissal of this case, but solely on the ground that United Seniors

lacked standing because the MSP private action was not a *qui tam* provision along the lines of the FCA model. Pet.App. 9a-16a. According to the court of appeals, only Medicare beneficiaries can bring a private MSP case. Pet.App. 14a. *See also* Pet.App. 9a (It is a "fatal defect" that plaintiff does not represent "any particular Medicare beneficiary who received unreimbursed Medicare payments for treatment of smoking-related injuries.").

REASONS FOR GRANTING THE PETITION

The court of appeals has constructed a standard for *qui tam* legislation squarely in conflict with this Court's precedents, a standard that most *qui tam* statutes enacted by Congress over the generations would fail. The decision below also fundamentally distorts this Court's standing jurisprudence. While it purports to apply this Court's teaching on injury-in-fact, it recognizes the standing to bring an MSP action only of Medicare beneficiaries who have no more suffered any injury remedied by the MSP than has United Seniors. And this decision is but the lead case among over 50 like it in the lower courts. This posture alone would warrant further review.

Yet far more is at stake. Congress enacted MSP to prevent other insurers from exploiting Medicare by forcing Medicare to foot the bill for liabilities those other insurers should pay. By recovering Medicare's money from the correct primary payer, the MSP

private action, like other *qui tam* suits, is designed to rally private citizens to amplify the government's efforts to protect the public fisc. More than at any time in recent memory, Medicare, and the millions of seniors who depend on it, can ill-afford the disabling of such a potent tool by the lower courts. Accordingly this case is a timely vehicle for a definitive ruling by this Court on an issue that has hindered effective administration of an important federal program, that has been involved in numerous cases below, and that will continue to be the subject of widespread litigation until it is settled by this Court.

I. THE COURT OF APPEALS' DECISION CONFLICTS WITH THIS COURT'S *QUI TAM* AND STANDING JURISPRUDENCE.

A. The Court of Appeals' Holding That Congress Must Mimic The Provisions of the False Claims Act to Create a *Qui Tam* Action Is Directly At Odds With This Court's Precedents.

1. The court of appeals held that the MSP private cause of action is not a *qui tam* provision, and that only a Medicare beneficiary can bring such a suit. Pet.App. 9a, 14a. Yet that result is not found in the text of the statute. *See* 42 U.S.C. §1395y(b)(3)(A) ("There is established a private cause of action. . . ."). Violating the most elementary norm of statutory construction, the court below did not "begin . . . with the language of the statute." *Duncan v. Walker*, 533 U.S. 167, 172 (2001). It did not suggest that the

provision was ambiguous, or, if so, seek to clarify its meaning by examination of "the remainder of the statutory scheme." *United Savings Ass'n of Texas v. Timbers of Inwood Forest Assoc., Ltd.,* 484 U.S. 365, 371 (1988). In short, it did not examine the language of MSP to determine what *Congress* meant to say. *See Hartford Underwriters Ins. Co. v. Union Planters Bank, N.A.,* 530 U.S. 1, 6 (2000).

Instead, the court of appeals leapt to an extended evaluation of MSP by reference to the FCA. It did so based on a very dubious premise:

> Congress created the causes of action in FCA §3730(b) and MSP §1395y(b)(3)(A) during the *same month* in 1986, and if it had meant unambiguously to create a *qui tam* action in the latter section, it readily could have used – but did not – the same explicit assignment language it employed in §3730(b) (*viz.* "a person may bring a civil action . . . the person and for the United States").

Pet.App. 11a.

This is simply wrong: the *qui tam* cause of action in the FCA was created *not* in 1986, but in 1863; the statute was amended in 1986. *See Marcus,* 317 U.S. at 539-40; *Vermont Agency,* 529 U.S. at 781-86; C. SYLVIA, THE FALSE CLAIMS ACT: FRAUD AGAINST THE GOVERNMENT, §§2:6, 2:9 (2004). And whether or not one Congress "readily could have used" language

employed by a Congress a century earlier,[10] the fact that it did not establishes nothing – certainly not that the MSP private action is not a *qui tam* provision and certainly not in the absence of any examination of the MSP statute and regulations themselves.

The court of appeals went on to conclude that the MSP did not measure up to the FCA model in three ways. First, MSP does not "make clear, whether expressly or by necessary implication, that the plaintiff is an assignee of the government entitled to sue in its behalf." Pet.App. 16a. Second, MSP makes no provision for sharing any recovery with the government. Pet.App. 12a. Third, MSP lacks "special procedural limitations ... designed to ensure that the government is to be kept informed and permitted to determine the extent to which it will participate in the litigation." Pet.App. 13a.

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[10] In the FCA, Congress was amending the existing *qui tam* provisions of a century-old statute addressing all manner of frauds against the government. In the MSP, Congress was adding a *qui tam* provision to an existing regime enforcing limits on a specific spending program run by a particular agency. Different committees and members of Congress lead each effort. *See Manning*, 254 F.3d at 397 n.8; SYLVIA, *supra*, at §2:9. The analysis of the court below is redolent of the criticism, voiced by three Justices in another context, to the effect that the court "adandon[ed] all attempt at construction of *this* statute and leaps to its interpretation over a quarter century ago of another statute enacted by a different Congress, a statute with a distinct history and purpose." *Communications Workers of America v. Beck*, 487 U.S. 735, 764 (1988) (Blackmun, O'Connor, Scalia, JJ., concurring in part and dissenting in part).

Each of these conclusions is wrong, both insofar as they purport to represent some universal standard for genuine *qui tam* provisions and insofar as they purport to describe the MSP's private action. Most importantly, these conclusions embody an analysis long rejected by this Court. This catalog of detailed provisions that, according to the court of appeals, must be included in congressional efforts to employ *qui tam* echoes the "interpretive approach" that this Court could "not accept" in *Marcus* – construction of a *qui tam* statute with the "utmost strictness" due to the "disfavor" with which the lower courts regarded *qui tam*. 317 U.S. at 541.

This Court's *qui tam* jurisprudence has been fundamentally shaped by historical practice and tradition. *See, e.g., id.* at 541 n.4 ("Statutes providing for actions by a common informer, who himself had no interest whatever in the controversy other than that given by statute, have been in existence . . . in this country ever since the foundation of our government." (quoting *Marvin v. Trout,* 199 U.S. 212, 225 (1905)); *Vermont Agency,* 529 U.S. at 774-77. Within that history, the model of the FCA that the court of appeals elevated as its analytical standard is unique, not a litmus test for all *qui tam* actions. The statutory text of a *qui tam* provision can be quite Spartan: "[s]tatutes providing for a reward to informers which do not specifically either authorize or forbid the informer to institute the action are construed to authorize him to sue." *Marcus,* 317 U.S. at 541 n.4. Congress can even let the *qui tam* plaintiff keep *all*

the recovery. *Marvin,* 199 U.S. at 226 ("There can be no doubt of the right of the government to give the whole instead of a moiety of the forfeiture to the informer.").

It is not surprising, then, that many past or current *qui tam* statutes do not contain one or more of the elements the court of appeals thought necessary. *See, e.g.,* 35 U.S.C. §292(b) ("Any person may sue for the penalty [for patent infringement], in which even one-half shall go to the person suing and the other to the use of the United States."); 46 U.S.C. §80103 ("A forfeiture under this subsection [for taking undersea treasure from the Florida coast] accrues half to the informer and half to the Government."). *See also Vermont Agency,* 529 U.S. at 777 n.7 (examples of *qui tam* statutes only providing for a bounty with no express cause of action). That so many lower courts have recently followed this "interpretive approach" so fundamentally at odds with this Court's jurisprudence makes acutely evident the need for this Court to address these issues now.

2. The MSP private action fits comfortably within the body of *qui tam* statutes Congress has enacted in the past. As this Court has explained, a *qui tam* statute

> is intended to protect the treasury against the hungry and unscrupulous host that encompasses it on every side, and should be construed accordingly. It was passed upon the theory, based on experience as old as modern civilization, that one of the least

> expensive and most effective means of preventing frauds on the treasury is to make the perpetrators of them liable to actions by private persons acting . . . under the strong stimulus of personal ill will or the hope of gain.

Marcus, 317 U.S. at 541 n.5. In MSP, it is Medicare that is to be protected, and surely no contemporary federal program has been a fatter target for the "unscrupulous host" that would wrongly profit from it. MSP sets the boundaries on what Medicare will pay when other insurers are liable, and when those insurers do not pay, MSP empowers private citizens to sue to right that "economic wrong done to the government." *Manning,* 254 F.3d at 394. *See also Mason v. American Tobacco Co.,* 212 F.Supp.2d 88, 94 (E.D.N.Y. 2002), *aff'd on other grounds,* 346 F.3d 36 (2d Cir. 2003) (MSP "authorizes a civil proceeding similar to a *qui tam* action where anyone can bring a claim on behalf of the United States government and receive a bounty."). No private interest of a Medicare beneficiary exists in an MSP case; it is an action that can *only* be brought on behalf of a governmental interest.

MSP provides "a financial incentive for private citizens to bring such suits," *Manning,* 254 F.3d at 394, by awarding double damages in a successful private action. 42 U.S.C. §1395y(b)(3)(A). The MSP "private attorneys general" only "receive[s] part of the recovery," *Manning,* 254 F.3d at 394, the statute and the regulations commanding that Medicare's

expenditures be fully reimbursed from that recovery, §1395y(b)(2)(B)(iii); 42 C.F.R. §§411.22(a), 411.24(g), adjusted in certain circumstances of less than full recovery, §411.37(a), (c) & (d), or reduced by waiver from Medicare. §§401.613, 411.28. Finally, the government may intervene in an MSP private action. 42 C.F.R. §411.26(b).

In sum, not only can the MSP private action be understood as nothing other than a *qui tam* suit, it actually contains in substance all the elements the court below said were necessary.

B. The Court of Appeals' Holding That Only An Injured Medicare Beneficiary Has Standing to Bring An MSP Private Action – When That Beneficiary Has Not Suffered, And Cannot Suffer, The Sole Injury MSP Remedies – Is Illogical And Distorts This Court's Precedents Concerning Injury-In-Fact.

A *qui tam* plaintiff has Article III standing to assert the injury-in-fact suffered by the government as a partial assignee of the government's claim. *Vermont Agency,* 529 U.S. at 773-74. If, as the court of appeals held, the MSP private action is not a *qui tam* provision, the question then becomes who can use it and meet traditional standing requirements. Pet.App. 8a-9a. The court below "assum[ed] . . . that only Medicare beneficiaries can prosecute a private §1395y(b)(3)(A) cause of action." Pet.App. 14a. The court never explained the basis of this assumption

except in passing by criticizing the failure of United Seniors to represent "any particular Medicare beneficiary who received unreimbursed Medicare payments for treatment of smoking-related injuries." Pet.App. 9a. This abrupt treatment betrayed a complete misunderstanding of MSP and of the operation of Medicare. More fundamentally, it profoundly distorts this Court's standing jurisprudence to hold, as the court below did, that a Medicare beneficiary has suffered an injury-in-fact redressable in an MSP private action.

First, the statute itself does not provide any limit on who may be an MSP private plaintiff. "The MSP statute does not by its terms require each individual covered by Medicare to bring suit." *Mason,* 212 F.Supp.2d at 94. The MSP private action, §1395y(b)(3)(A), like the government's MSP action,[11] §1395y(b)(2)(B)(iii), authorizes suit to be brought to recover Medicare's expenditures from the insurer who was responsible to pay a Medicare beneficiary's medical bills, but did not. The MSP private action does not seek to recover any money that a Medicare beneficiary spent, nor does it seek a remedy for any other injury suffered by a Medicare beneficiary. Contrary to the court of appeals' opinion, neither

[11] The MSP private action expressly cross-references and incorporates §1395y(b)(2)(A), which in turn expressly incorporates §1395y(b)(2)(B), the provisions setting out the right of Medicare to be reimbursed and the government's enforcement mechanism.

MSP nor its enforcement mechanisms implicates in any way a "Medicare beneficiary who received unreimbursed Medicare payments," Pet.App. 9a, except when a beneficiary is being sued under MSP because that beneficiary has received a payment from a primary insurer that should go to Medicare. *See* §1395y(b)(2)(B)(iii) (recovery may be sought "from any entity that has received payment from a primary plan"). Thus, far from the court of appeals' selection of such a Medicare beneficiary as the only MSP plaintiff, the statute contemplates that such a beneficiary is, if anything, an MSP *defendant*.

Moreover, it is a profound distortion of this Court's precedents to hold, as did the court below, that such a beneficiary has Article III standing. It is elementary that "the party bringing suit must show that the action injures him in a concrete and personal way." *Lujan,* 504 U.S. at 581 (Kennedy, J., concurring in part and concurring in the judgment). The money sought in an MSP action is not money spent by a Medicare beneficiary. No injury personally suffered by a Medicare beneficiary is remedied by MSP.

The only money recovered in an MSP action is tax dollars spent by Medicare. The injury to be remedied in an MSP private action, then, "is based on the asserted effect of . . . allegedly illegal activity on public revenues, to which the taxpayer contributes." *DaimlerChrysler Corp. v. Cuno,* 126 S.Ct. 1854, 1862 (2006). If one assumes, as did the court below, that the MSP private action is not a *qui tam* provision, then the search for the proper plaintiff should

logically lead to all who paid the taxes to fund Medicare. As a taxpayer protection organization, Pet.App. 59a-60a, United Seniors would surely have a legitimate claim to such standing. Yet this Court has unequivocally rejected such standing claims as this taxpayer injury is "not 'concrete and particularized.'" *DaimlerChrysler Corp.*, 126 S.Ct. at 1862 (quoting *Lujan,* 504 U.S. at 560). It is an injury that a taxpayer "suffers in some indefinite way in common with people generally." *Frothingham v. Mellon*, 262 U.S. 447, 488 (1923). If the MSP private action is not a species of *qui tam*, then the relief achieved by it "no more directly and tangibly benefits" a Medicare beneficiary, United Seniors, or anyone other than the government, "than it does the public at large." *Lujan,* 504 U.S. at 574.

In short, if the MSP private action is not a *qui tam* statute, then *no one* could bring an MSP private action. The entire provision would be superfluous. That simply cannot be a correct reading of the statute. *See Duncan,* 533 U.S. at 174; 2A N. SINGER, SUTHERLAND ON STATUTORY CONSTRUCTION §46.6 (7th ed. 2007). The court of appeals strained to avoid recognizing the MSP private action as a *qui tam* suit, but in so doing utterly distorted this Court's elementary teaching on standing.

II. THE COURT OF APPEALS' DECISION UNDERMINES CONGRESS' EFFORTS TO PREVENT THE EXPLOITATION OF MEDICARE BY OTHER INSURERS.

Medicare is a critical source of health care funding for millions of Americans. In 2006, with 43.2 million beneficiaries, Medicare had expenditures of $408 billion. 2007 ANNUAL REPORT OF THE BOARDS OF TRUSTEES OF THE FEDERAL HOSPITAL INSURANCE AND FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUNDS 2 *available at* http://www.cms.hhs.gov/ReportsTrustFunds/downloads/tr2007.pdf. "The financial outlook for the Medicare program continues to raise serious concerns." *Id.* at 4. Within six years, Medicare taxes will fall short of Medicare expenses by more than 45 percent. *Id.* at 2. The hospital insurance trust fund "is projected to be exhausted in 2019." *Id.* at 3.

Medicare's financial vulnerability has been a recurrent spur to Congressional action since 1980, when "skyrocketing Medicare costs" moved Congress to begin the enactment of MSP. *Zinman v. Shalala,* 67 F.3d 841, 843 (9th Cir. 1995). "By enacting the MSP provisions, 'Congress sought to reduce Medicare spending and to insure the continued integrity of the Medicare program.'" *Baptist Memorial Hosp. v. Pan American Life Ins. Co.* 45 F.3d 992, 997 (6th Cir. 1995) (quoting *Provident Life & Accid. Ins. Co. v. United States,* 740 F.Supp. 492, 495 (E.D.Tenn. 1990)). Since 1980, "Congress has expanded [MSP's] reach several times, making Medicare secondary to a greater array of primary coverage sources, and

creating a larger spectrum of beneficiaries who no longer may look to Medicare as their primary source of coverage." *Baxter,* 345 F.3d at 877. Indeed, MSP's legislative history, limited though it is, "indicates that Congress was dissatisfied that Medicare was not recouping as much from primary payers as it could." *Id.* at 891 n.16. As one Senate leader put it:

> Unfortunately, performance under the MSP Program has not measured up. Failure to follow the MSP law is costing the taxpayer billions of dollars. . . . Studies by the General Accounting Office and the inspector general of the Department of Health and Human Services have repeatedly identified the MSP program as gushing with leaks of Federal tax dollars.

Id. (quoting 136 Cong.Rec. S13419-01 (daily ed. Sept. 19, 1990) (statement of Sen. Roth)).

GAO has explained the practical challenge of MSP enforcement:

> MSP efforts have reduced Medicare costs by billions of dollars. However, the process of identifying the instances where Medicare is the secondary payer and recovering mistaken Medicare payments is labor intensive, expensive, and often unreliable. Enforcing the MSP provisions has been a longstanding challenge and, despite efforts by [CMS] and the millions of dollars spent to identify primary payers, hundreds of millions of Medicare dollars remain uncollected.

L. Aronovitz, GAO Assoc. Director, *Medicare Secondary Payer Program: Identifying Beneficiaries With Other Insurance Coverage Is Difficult* at 1, Testimony Before the Subcomm. on Regulation and Govt. Information, Senate Comm. on Govt'l Affairs, GAO/T-HRD-93-13 (April 2, 1993).

The Government simply does not have the resources to pursue private insurers to secure the reimbursement of Medicare on the scale needed.[12] The GAO has reported on the lack of progress that has been made in collecting MSP debts, which "arise when Medicare covers expenses related to accidents, malpractice, workers' compensation, or other items not associated with group health plans that are subsequently determined to be the responsibility of another payer." GAO, DEBT COLLECTION IMPROVEMENT ACT OF 1996: HHS'S CENTERS FOR MEDICARE & MEDICAID SERVICES FACES CHALLENGES TO FULLY IMPLEMENT CERTAIN KEY PROVISIONS, 20 (2002). According to GAO, Medicare "lacks information on the total dollar amount of eligible debts not covered by its current referral instructions to Medicare contractors, and it has not developed a detailed plan or specific time

[12] With respect to just one class of primary payers, group health plans, GAO has reported that "[t]he current system for recovering MSP debt from [group health plans] is no longer cost-effective. [In 2003], Medicare recovered only 38 cents for every dollar it spent on recovery activities associated with [group health plans]." GAO, MEDICARE SECONDARY PAYER: IMPROVEMENTS NEEDED TO ENHANCE DEBT RECOVERY PROCESS 3, GAO-04-783 (2004).

frame for referring these debts." *Id.* at 19. Moreover, Medicare does not even try to collect older MSP debts because it believes it is "not cost-effective to collect them." *Id.* at 16.

When MSP is not enforced, taxpayers subsidize private insurers by paying for medical costs those other insurers should pay for. To halt this exploitation of Medicare, "Congress has repeatedly clarified and augmented the Government's powers to recoup conditional Medicare payments from primary sources." *Baxter,* 345 F.3d at 877. The 1986 addition of the private cause of action was a major step in this strengthening of MSP enforcement designed "to save the government money by giving private citizens incentives to recover funds erroneously paid by Medicare." *Manning,* 245 F.3d at 397 n.8. *Cf. Agency Holding Corp. v. Malley-Duff & Assoc., Inc.,* 483 U.S. 143, 151 (1987) ("Both [RICO and the Clayton Act] bring to bear the pressure of 'private attorneys general' on a serious national problem for which public prosecutorial resources are deemed inadequate.").

Like the FCA's *qui tam*, MSP's private action serves "to quicken the self-interest of some private plaintiff who can spot violations and start litigating to compensate the Government, while benefiting himself as well." *Chandler,* 538 U.S. at 131. The performance of the FCA *qui tam* suggests the potential of the MSP private action. Hundreds of FCA *qui tam* cases are filed each year. In FY 2003, a record $2.1 billion was recovered under the FCA, and of that sum a staggering 70 percent was recovered in *qui tam*

suits brought by citizens. Dept. of Justice Press Release No. 613, at 1 (Nov. 10, 2003), *available at* www.usdoj.gov/opa/pr/2003/November/03_civ_613.htm. *See also id.* ("Without . . . the qui tam provisions that give everyone who comes in contact with a federally funded program a stake in reporting fraud, such recoveries would not have been possible." (quoting Assistant Attorney General P. Keisler)). "From fiscal years 1987 through 2005, settlements and judgments for the federal government in FCA cases have exceeded $15 billion, of which $9.6 billion, or 64 percent, was for cases filed . . . under FCA's qui tam provisions." GAO, *Information on False Claims Act Litigation*, at 1, GAO-06-320R (Jan. 31, 2006).

MSP, in contrast, has been handicapped by "disagreement among the courts as to its proper interpretation," *Brown,* 374 F.3d at 260, that generated narrow constructions of the statute blocking MSP enforcement against self-insured corporations that injured Medicare beneficiaries. Yet the promise of Congress' design for MSP remains. During consideration of the 2003 clarification that effectively overrode these constructions, the Congressional Budget Office concluded that the clarified MSP had the potential to restore over $9 billion to Medicare over 10 years. 149 CONG.REC. S15574, S15585 (daily ed. Nov. 22, 2003) (statement of Sen. Grassley).

With the 2003 clarification, judicial hurdles to enforcing MSP were swept away, stimulating precisely what Congress intended – new MSP cases seeking to recover Medicare's expenditures for various

mass torts injuring seniors. But with the notion that the MSP private action is not a *qui tam* provision at all – embraced by the First Circuit here and by many other lower courts – a new, more fundamental, barrier has been raised completely halting any serious private role in MSP enforcement. This error is a crippling blow to Congress' MSP enforcement regime. As a result, we face the continuing prospect of other insurers being massively enriched at the expense of the employees, employers, and others who pay the taxes funding Medicare. This enormous potential liability that turns on the question of statutory construction at issue in this case is a strong factor in favor of granting certiorari. *See, e.g.*, R. STERN, ET AL., SUPREME COURT PRACTICE 248 (8th ed. 2002). The Court should grant this petition to assess whether such consequences really are what the law requires.

III. THIS CASE PRESENTS AN IDEAL VEHICLE FOR THE COURT TO REMOVE THE BARRIER ERECTED BY THE LOWER FEDERAL COURTS TO MSP'S PROTECTIONS FOR MEDICARE'S RESOURCES.

Either the MSP private action is a *qui tam* provision or it is not. The issue presented by this petition does not admit of shadings or intermediate legal positions. The ruling below represents a phalanx of opinions from the lower courts holding that only a Medicare beneficiary can use the MSP private action to recover Medicare's expenditures for his health care.

To be sure, the Second Circuit in *Manning* concluded that the FCA *qui tam* and the MSP private action are "similar" in that both mobilize private citizens to sue on behalf of the Government "to right an economic wrong done to the government." 254 F.3d at 394. Yet the Second Circuit was addressing the question of what statute of limitations should apply in an MSP private action, not the standing of the private litigant. Moreover, an isolated and somewhat ambiguous dictum in *Manning* arguably confuses any evaluation of what that court's position might be on who may bring an MSP private action. *See id.*

With at least 50 district courts marching in lockstep with the First Circuit's analysis, it is unlikely that another Circuit might hold differently. Moreover, the opinion below sets out the fully developed reasoning of the lower courts supporting the notion that the MSP private action is not a *qui tam* statute. No better case presenting this issue is likely to come before this Court.

Meanwhile, the drain of the taxpayers' Medicare dollars benefiting private insurers continues apace. Further "percolation" of the MSP standing issue in the courts below is thus both unnecessary and truly costly.[13] This body of judicial interpretations hostile to

[13] The frustration of Congress' goal of halting the financial exploitation of Medicare by other liable insurers is truly poignant in this case. As the court of appeals noted, but did not address, United Seniors contended below that the extensive findings of fact by the court in *United States v. Philip Morris,*

(Continued on following page)

MSP's private action cripples Congress' repeated efforts to prevent Medicare's strained resources from paying for the liabilities for which other insurers are responsible.

Resolving this threshold issue will not resolve other issues – such as the *Glover* two-lawsuit rule – that will still encumber MSP enforcement. Yet resolving this standing issue now will either allow private litigants to press forward on these other issues to recover Medicare's money, or will inform Congress that further action by it is necessary. Accordingly, a definitive ruling by this Court on the question of who may bring an MSP private action is acutely needed and should not be delayed. The Court should grant this petition.

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449 F.Supp.2d 1, has established the liability of the defendants for the battery alleged here, either as a matter of collateral estoppel or in satisfaction of any asserted two-lawsuit rule. *See* Pet.App. 7a. And that ruling came eight years after the tobacco companies' $246 billion settlement (paid over 25 years) of similar cases brought by State Medicaid programs. *See* Master Settlement Agreement, *available at* http://ag.ca.gov/tobacco/pdf/1msa.pdf?PHPSESSIS=dd4cfa60e212853099551a211bf95b19. Approximately 7.5 million seniors are enrolled in both Medicare and Medicaid. *See* Kaiser Commission on Medicaid Facts, *available at* http://www.kff.org/medicaid/upload/4091-04%20FINAL(v2).pdf.

CONCLUSION

For the foregoing reasons, this petition for a writ of certiorari should be granted.

Respectfully submitted,

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November 14, 2007

500 F.3d 19

United States Court of Appeals, First Circuit.

UNITED SENIORS ASSOCIATION, INC.,
As a Private Attorney General, Plaintiff, Appellant,

v.

PHILIP MORRIS USA, R.J. Reynolds Tobacco Company, Brown & Williamson Tobacco Corporation, Individually and as the Successor to the American Tobacco Company, Lorillard Tobacco Company, and Liggett Group, Inc., Defendants, Appellees.

No. 06-2447.

Heard March 6, 2007.
Decided Aug. 20, 2007.

Appeal from the United States District Court for the District of Massachusetts, Richard Stearns, U.S. District Judge.

Robert J. Cynkar, with whom Joseph R. Egan, Charles J. Fitzpatrick, Egan, Fitzpatrick, Malsch & Cynkar, PLLC, Christopher Weld, Jr., Kevin T. Peters, Raymond P. Ausrotas, Todd & Weld LLP, Jonathan W. Cuneo, Michael G. Lenett, and Cuneo, Gilbert & LaDuca, LLP, were on brief for appellant.

Richard B. Rosenthal, with whom Brian Stuart Kaukautchos was on brief for amicus.

Murray R. Garnick, with whom Arnold & Porter LLP, Robert A. McCarter III, Geoffrey J. Michael, Conn, Kavanaugh, Rosenthal, Peisch & Ford, LLP, Thomas E. Peisch, and Erin K. Higgins, were on brief for appellees.

Before BOUDIN, Chief Circuit Judge, CYR, Senior Circuit Judge, and HOWARD, Circuit Judge.

CYR, Senior Circuit Judge.

United Seniors Association, Inc. ("United Seniors"), a nonprofit taxpayer advocacy group, appeals from a district court judgment dismissing its claims pursuant to the Medicare Secondary Payer ("MSP") statute, 42 U.S.C. § 1395y(b)(3)(A), to force five tobacco companies to reimburse the federal Medicare program for the monies it has expended since 1999 for the medical treatment of persons suffering from smoking-related illnesses. The district court concluded that United Seniors could not file such a private § 1395y(b)(3)(A) cause of action for reimbursement before the tobacco companies' financial responsibility to pay for the Medicare beneficiaries' medical expenses had been determined by a judgment, compromise, waiver, or a release from the beneficiaries of their insurance claims against the companies, or some other comparable means. *United Seniors Ass'n v. Philip Morris USA,* No. 05-11623, 2006 WL 2471977, at *3-4 (D.Mass. Aug.28, 2006). We affirm the judgment of dismissal, albeit on another ground.

I

BACKGROUND

A. *The MSP Statute*

Prior to 1980, Medicare generally paid for medical services whether or not the Medicare beneficiary

also was covered by another health plan. *See Fanning v. United States,* 346 F.3d 386, 388 (3d Cir.2003) (citing Social Security Amendments of 1965, Pub.L. No. 89-97, § 1862(b), 79 Stat. 286). The MSP statute, which was enacted in 1980 to reduce federal health care costs, makes Medicare the secondary payer for medical services provided to Medicare beneficiaries whenever payment is available from another primary payer. *See United States v. R.I. Insurers' Insolvency Fund,* 80 F.3d 616, 618 (1st Cir.1996) (citing H.R.Rep. No. 96-1167, at 389 (1980), *reprinted in* 1980 U.S.C.C.A.N. 5526); *see also Glover v. Liggett Group, Inc.,* 459 F.3d 1304, 1306-07 (11th Cir.2006).

To that end, the MSP statute prohibits Medicare from making any payment to a beneficiary for medical expenses if "payment has been made, or can reasonably be expected to be made promptly (as determined in accordance with regulations) under . . . an automobile or liability insurance policy or plan (including a self-insured plan) or under no-fault insurance." *R.I. Insurers' Insolvency Fund,* 80 F.3d at 618 (quoting 42 U.S.C. § 1395y(b)(2)(A)(i)). Should Medicare determine that the primary insurer has not paid and that no prompt payment reasonably can be expected from the primary insurer, however, Medicare may pay the beneficiary up front, but such payment is conditioned on Medicare's right to reimbursement in the event that a primary plan later

pays or is found responsible for payment of the item or service. *See id.* (citing 42 U.S.C. § 1395y(b)(2)(B)).[1]

To facilitate recovery of these conditional payments, the MSP (i) provides for a government action against any entity responsible for payment under a primary plan, 42 U.S.C. § 1395y(b)(2)(B)(iii);[2]

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[1] The reimbursement provision reads:

> A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this subchapter with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means.

42 U.S.C. § 1395y(b)(2)(B).

[2] Section (b)(2)(B)(iii), entitled "Action by United States," provides, in pertinent part:

> In order to recover payment made under this subchapter for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity.

(Continued on following page)

(ii) subrogates the United States to the rights of a Medicare beneficiary to collect payment under a primary plan for items already paid by Medicare, § 1395y(b)(2)(B)(iv) ("The United States shall be subrogated (to the extent of payment made under this subchapter for such an item or service) to any right under this subsection of an individual or any other entity to payment with respect to such item or service under a primary plan."), and (iii) creates a private cause of action with double recovery to encourage private parties to bring actions to enforce Medicare's rights, § 1395y(b)(3)(A) ("There is established a private cause of action for damages (which shall be in an amount double the amount otherwise provided) in the case of a primary plan which fails to provide for primary payment (or appropriate reimbursement) in accordance with paragraphs (1) and (2)(A).").[3] The present case implicates only the private cause of action provision.

In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity.

[3] In 2001, the government's direct MSP reimbursement collection action against the major tobacco companies was dismissed in a related federal district court lawsuit, and the government has never sought to reinstate its claim. *See United States v. Philip Morris, Inc.*, 449 F.Supp.2d 1, 32 (D.C.C.2006).

B. *United Seniors' Lawsuit*

On August 4, 2005, United Seniors filed the instant action against five major tobacco companies in Massachusetts federal district court, demanding reimbursement for all smoking-related Medicare costs incurred since 1999,[4] and also alleging that the tobacco companies were liable for the tort of battery. Plaintiff's complaint does not allege that any of its members are Medicare beneficiaries who were treated for smoking-related injuries, but simply invokes the private-cause-of-action provision set forth in § 1395y(b)(3)(A). Plaintiff contends that § 1395y(b)(3)(A) is available to any person who seeks to force a primary insurer to reimburse costs to Medicare, not only to affected Medicare beneficiaries.

Defendants moved to dismiss the complaint on three grounds: (i) United Seniors, which does not allege that any of its members were Medicare beneficiaries treated for smoking-related illnesses, possesses neither Article III nor statutory standing to maintain a § 1395y(b)(3)(A) reimbursement suit; (ii) United Seniors was in privity with the losing plaintiff

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[4] United Seniors' complaint excludes Medicare beneficiaries residing in Florida. A separate § 1395y(b)(3)(A) lawsuit had been filed in Florida federal district court in behalf of Florida Medicare beneficiaries. However, as in this case, the court dismissed the complaint on the ground that plaintiffs did not establish that the tobacco companies' financial responsibility to pay for the beneficiaries' medical expenses had been established through an earlier judgment or some other comparable means. *Glover*, 459 F.3d at 1309.

in *Glover,* 380 F.Supp.2d at 1309; *see supra* note 4, and consequently is collaterally estopped from relitigating the defendants' reimbursement obligations to Medicare; and (iii) United Seniors failed to allege that defendants' financial responsibility for unreimbursed Medicare costs had been established previously by judgment, compromise, waiver, nor by a release from the beneficiaries of their insurance claims against the companies, nor by any other comparable means. On August 28, 2006, the district court dismissed the United Seniors complaint on the third ground alone, citing the rationale in *Glover. United Seniors,* 2006 WL 2471977, at *4.[5]

II

DISCUSSION

The defendants' Article III and statutory-standing argument, which calls into question our

[5] After the entry of judgment, United Seniors brought to the attention of the court the recently-issued opinion in *United States v. Philip Morris USA, Inc.,* 449 F.Supp.2d 1 (D.C.C.2006) (finding that major tobacco companies violated the Racketeer Influenced and Corrupt Organizations Act by deceiving the public concerning the addictiveness of cigarettes and by manipulating their cigarettes' design to enhance addictiveness), arguing that its factual findings would serve as the requisite "prior judgment" demonstrating the defendants' financial responsibility for Medicare beneficiaries' smoking-related health care expenditures. The district court summarily rejected the contention. As we affirm on an alternative ground, *see infra,* we do not address the relevance *vel non* of the RICO judgment.

subject-matter jurisdiction, rests on Federal Rule of Civil Procedure 12(b)(1). The federal courts are required to determine whether Article III jurisdiction exist prior to proceeding to the merits of the case. *See United States v. Union Bank for Sav. & Inv.*, 487 F.3d 8, 22 (1st Cir.2007) (citing *Steel Co. v. Citizens for Better Env't*, 523 U.S. 83, 94, 118 S.Ct. 1003, 140 L.Ed.2d 210 (1998)); *see also Davignon v. Clemmey*, 322 F.3d 1, 11 (1st Cir.2003) (holding that an appellate court remains free to bypass problematic jurisdictional issues provided those issues do not implicate the Article III "case or controversy" requirement); *Dubois v. United States Dep't. of Agric.*, 102 F.3d 1273, 1281 (1st Cir.1996); *accord In re Olympic Mills Corp.*, 477 F.3d 1, 6 (1st Cir.2007) (noting that "'we have an obligation to inquire *sua sponte* into our jurisdiction over the matter'") (citation omitted). We review *de novo* the district court's implicit legal conclusion that it had subject-matter jurisdiction to determine the merits of the complaint, *see Baella-Silva v. Hulsey*, 454 F.3d 5, 10 (1st Cir.2006), and conclude that United Seniors lacks Article III standing.

Article III standing requirements "are expressed in a familiar three-part algorithm: a would-be plaintiff must demonstrate a concrete and particularized injury in fact, a causal connection that permits tracing the claimed injury to the defendant's actions, and a likelihood that prevailing in the action will afford some redress for the injury." *Me. People's Alliance & Natural Res. Def. Council v. Mallinckrodt, Inc.*, 471

F.3d 277, 283 (1st Cir.2006) (citing *Lujan v. Defenders of Wildlife,* 504 U.S. 555, 560-61, 112 S.Ct. 2130, 119 L.Ed.2d 351 (1992)). United Seniors, suing in its capacity as a nonprofit taxpayer advocacy group to vindicate the fiscal integrity of the Medicare program, utterly fails to meet this standard, in that it does not allege that it represents any particular Medicare beneficiary who received unreimbursed Medicare payments for treatment of smoking-related injuries. *See id.* (noting that an association has Article III standing only if its "individual members would have standing to sue in their own right"); *Osediacz v. City of Cranston,* 414 F.3d 136, 142 (1st Cir.2005) ("[W]ith certain narrow exceptions not implicated here, taxpayers, as such, lack generalized standing to challenge the constitutionality of governmental action.") (citing *Frothingham v. Mellon,* 262 U.S. 447, 487, 43 S.Ct. 597, 67 L.Ed. 1078 (1923)).

In order to overcome this fatal defect, United Seniors argues that Congress sought to create a *qui tam* action in § 1395y(b)(3)(A). *See Vt. Agency of Natural Res. v. United States ex rel. Stevens,* 529 U.S. 765, 773, 120 S.Ct. 1858, 146 L.Ed.2d 836 (2000) (holding that *qui tam* plaintiffs have Article III standing because they sue as partial assignees of the United States' claims against defendants). We find no evidence of such congressional intent.

There presently is no common-law right to bring a *qui tam* action, which is strictly a creature of statute. *See id.* at 776; *Conn. Action Now, Inc. v. Roberts Plating Co.,* 457 F.2d 81, 84 (2d Cir.1972). "'*Qui tam*'

is an abbreviation for *qui tam pro domino rege quam pro seipso,* which literally means 'he who as much for the king as for himself.' *Qui tam* provisions first became popular in thirteenth century England. They permitted private individuals to bring suit on behalf of the King and served as a supplement to official law enforcement." *United States ex rel. Karvelas v. Melrose-Wakefield Hosp.,* 360 F.3d 220, 224 n. 5 (1st Cir.2004) (citation omitted). For example, the False Claims Act (FCA), 31 U.S.C. § 3729 *et seq.,* a typical and commonly-invoked *qui tam* action, provides that "[a] person may bring a civil action . . . *for the person and for the United States.*" 31 U.S.C. § 3730(b) (emphasis added). Although the government remains the "real party in interest" in a *qui tam* prosecution, *Karvelas,* 360 F.3d at 231, *qui tam* statutes like the FCA "authorize[] private individuals to sue on behalf of the federal government and were intended to aid the government in discovering fraud and abuse 'by unleashing a posse of *ad hoc* deputies to uncover and prosecute frauds against the government,'" *id.* at 224 (citation omitted). To encourage the efforts of these "private attorneys general," also known as "relators," *qui tam* statutes typically permit them to share – with the government – in the monetary recovery of the lawsuit. *See United States ex rel. S. Prawer and Co. v. Fleet Bank of Me.,* 24 F.3d 320, 324 (1st Cir.1994). As we noted, *supra, qui tam* relators, even those who were not personally injured by the defendant's actions, normally possess Article III standing because they sue as partial assignees of the United

States' claims against the defendant. *See Vt. Agency of Natural Res.*, 529 U.S. at 773.

By contrast to FCA § 3730(b), MSP § 1395y(b)(3)(A) reads, in its entirety: "There is established a private cause of action for damages (which shall be in an amount double the amount otherwise provided) in the case of a primary plan which fails to provide for primary payment (or appropriate reimbursement) in accordance with paragraphs (1) and (2)(A)." No mention is made of any jointly-held cause of action by the government and the private plaintiff, or of the private plaintiff's right to sue solely in behalf of the government. Indeed, the MSP contemplates that the government has its own independent causes of action, either direct or in subrogation. *See* 42 U.S.C. § 1395y(b)(2)(B)(iii), (iv); *supra* note 2.

Tellingly, Congress created the causes of action in FCA § 3730(b) and MSP § 1395y(b)(3)(A) during the *same month* in 1986,[6] and if it had meant unambiguously to create a *qui tam* action in the latter section, it readily could have used – but did not – the same explicit assignment language it employed in § 3730(b) (*viz.*, "a person may bring a civil action . . . for the person and for the United States") in § 1395y(b)(3)(A). *See Mullane v. Chambers*, 333 F.3d 322, 331 (1st Cir.2003) (consulting other statutes to ascertain that

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[6] *Compare* Pub.L. No. 99-509, § 9319, 100 Stat. 1874 (1986), *with* Pub.L. No. 99-562, § 3, 100 Stat. 3153 (1986).

Congress knew how to include an express exclusion "and could have done so clearly and explicitly"); *accord Wood v. Spencer,* 487 F.3d 1, 6 (1st Cir.2007) ("Congress acts intentionally and purposely when it includes particular language in one section of a statute but omits it in another.") (citation omitted).[7]

Furthermore, unlike the FCA and other *qui tam* statutes, MSP § 1395y(b)(3)(A) does not contemplate that the plaintiff share with the government in any monetary judgment. *Qui tam* statutes typically provide that the relator will receive, for example, a specific percentage of any recovery (or a "bounty"), with the remainder to go into the government coffers. *See, e.g.,* 31 U.S.C. § 3730(d)(1),(2) (authorizing FCA relator to recover 15-25% in a government-prosecuted case, and 25-30% in a self-prosecuted case); *see also Vt. Agency,* 529 at 777, n. 6 (setting forth congressional history of *qui tam* "informer" statutes, all of which provide for a particular percentage share of the recovery to relator). By contrast, MSP § 1395y(b)(3)(A) provides that the plaintiff is entitled to the *entire* recovery. It not only fails to mention a percentage bounty, but makes no provision at all requiring the prevailing plaintiff to share the double damages award with the government. In order to recover part of the judgment, presumably the government would need to commence an independent

[7] It is also particularly notable that the *Vermont Agency* Court did not list MSP § 1395y(b)(3)(A) as among the four *qui tam* statutes which "remain on the books." 529 U.S. at 768 n. 1.

lawsuit against the prevailing plaintiff pursuant to MSP § 1395y(b)(2)(B)(iii) or (iv). We cannot imagine that Congress intended the MSP to function as a *qui tam* statute in such an oblique fashion.

Finally, MSP § 1395y(b)(3)(A) fails to include any of the procedural mechanisms typical of *qui tam* statutes, which are predicated on the recognition that the government is the "real party in interest" in any *qui tam* prosecution. *See Karvelas,* 360 F.3d at 231. These special procedural limitations are designed to ensure that the government is to be kept informed and permitted to determine the extent to which it will participate in the litigation. *See Manning v. Utils. Mut. Ins. Co.,* 254 F.3d 387, 394 (2d Cir.2001).[8] Subsection 1395y(b)(3)(A) contains no such limitations, thus suggesting that the private plaintiff is meant to be the real party in interest.

United Seniors' only citations to the contrary are either inapposite or unpersuasive. In *Manning,* the

[8] The FCA contains the typical procedural safeguards. Prior to serving the complaint on the defendant, the relator must serve the complaint with the court under seal, disclose material evidence to the government, and thus allow the government an opportunity to conduct a preliminary investigation of the claim. *See* 31 U.S.C. § 3730(b)(2). The government then can choose to dismiss or settle the complaint (even over the relator's objection), to intervene and assume control of the case (in which event it is not bound by the relator's acts or representations), or to notify the court that it will permit the relator to prosecute the case. *Id.* § 3730(b)(4). Finally, the government is entitled to between 70-85% of any monetary judgment. *Id.* § 3730(d).

court stated that FCA § 3730(b) and MSP § 1395y(b)(3)(A) "allow individual citizens, as well as the government, to sue in order to right an economic wrong done to the government . . . [and] thus create 'private attorneys general' by authorizing private citizens to receive part of the recovery." 254 F.2d at 394. The *Manning* reference to "private attorneys general" is of little import. First, even assuming (as we do) that only Medicare beneficiaries can prosecute a private § 1395y(b)(3)(A) cause of action, those beneficiaries properly can be described as "private attorneys general" to the extent that their very power to sue coincidently serves a pro-government purpose: that of discouraging primary insurers from failing to reimburse Medicare and preventing depletion of the Medicare trust fund.

Further, the *Manning* court's above-quoted discussion arose in the more narrow and distinct context of determining which federal or state statute is "the most closely analogous" to the MSP, so that the MSP, which does not specify its own statute of limitations, could "borrow" its limitations period. In the process of identifying the "many important similarities" between the FCA and the MSP, however, the *Manning* court also noted "procedural differences." The court observed, for example, that the MSP "creates a private right of action *for individuals whose medical bills are improperly denied by insurers,*" whereas under the FCA, "a private citizen can sue to recover on a claim falsely submitted and paid by the United States, but such action is a relator action

brought in the name of the government." *Id.* at 394-95 (emphasis added). The *Manning* court then concluded that, "[d]espite these procedural differences, the FCA 'clearly provides a closer analogy than [New York] state [statute of limitations] alternatives.'" *Id.* at 395 (citation omitted).[9]

Finally, United Seniors cites no other apposite or persuasive authority to refute the rationale employed in the recent unbroken line of cases which have rejected the argument that MSP § 1395y(b)(3)(A) is a *qui tam* statute.[10]

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[9] We also discount the United Seniors' citation to *Mason v. Am. Tobacco Co.*, 212 F.Supp.2d 88 (E.D.N.Y.2002), where the court stated that the MSP statute authorizes "a civil proceeding *similar to a qui tam* action." *Id.* at 94 (emphasis added). Notably, the court did not state that the MSP statute *was* a *qui tam* statute. Further, the issue was discussed obliquely in the context as to whether to grant the plaintiffs' motion for class certification, not in the context of the plaintiffs' Article III or statutory standing. Finally, the class certification issue arguably was mooted by the court's prior ruling that the defendant-tortfeasors were not a "primary plan" for purposes of the version of § 1395(b)(3)(A) then in effect. *Id.* at 93. On appeal, the court affirmed the district court on this latter ground alone, and did not reach or address the certification or the *qui tam* issues. *See Mason v. Am. Tobacco Co.*, 346 F.3d 36, 43 (2d Cir.2003).

[10] *See, e.g., Stalley v. Regency Hosp. Co.*, No. 06-5233, 2007 WL 1702574 (W.D.Ark. June 11, 2007); *Brockovich v. Cmty. Med. Ctrs.*, No. 06-1609, 2007 WL 738691 (E.D.Cal. Mar.7, 2007); *Stalley v. Erlanger Health Sys.*, No. 1:06-194, 2007 WL 672301 (E.D.Tenn. Feb.28, 2007); *Stalley v. Catholic Health East*, No. 06-2491, 2007 WL 320271 (E.D.Pa. Jan.30, 2007); *Stalley v. Sumner Reg'l Health Sys., Inc.*, No. 2:06-0074, 2007 WL 173686

(Continued on following page)

United Seniors further suggests that the defendants' "standing" argument erroneously implies that the FCA is the sole prototype of a *qui tam* statute, and ignores the fact that other *qui tam* statutes have exhibited a variety of different characteristics. United Seniors contends that no "magic words" are necessary to find a *qui tam* and that it should be sufficient that a statute authorizes a private plaintiff to sue, but that clearly cannot be the benchmark. Many statutes authorize private causes of action by persons harmed by particular conduct, but this characteristic alone would not create a *qui tam* effect. At the very least, *qui tam* statutes must make clear, whether expressly or by necessary implication, that the plaintiff is an assignee of the government entitled to sue in its behalf. Subsection 1395y(b)(3)(A) simply does not come close to suiting this basic profile.

III

CONCLUSION

As we conclude that United Seniors failed to establish Article III standing to bring an action under MSP § 1395y(b)(3)(A), we lack the requisite subject matter jurisdiction to reach the district court's determination on the merits. *See Steel Co.*, 523 U.S. 83,

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(M.D.Tenn. Jan.18, 2007); *Stalley ex rel. United States v. Catholic Health Initiatives*, 458 F.Supp.2d 958, 962-63 (E.D.Ark.2006).

94-95, 118 S.Ct. 1003, 140 L.Ed.2d 210 (1998). Accordingly,

The appeal is hereby dismissed.

2006 WL 2471977

United States District Court,
D. Massachusetts.
UNITED SENIORS ASSOCIATION, INC.,
as a private attorney general

v.

PHILIP MORRIS USA, R.J. Reynolds Tobacco Company, Brown & Williamson Tobacco Corporation, individually and as the successor to The American Tobacco Company, Lorillard Tobacco Company, Inc., and Liggett Group, Inc.
Civil Action No. 05-11623-RGS.

Aug. 28, 2006.

Christopher Weld, Jr., Kevin T. Peters, Raymond P. Ausrotas, Todd & Weld, Boston, MA, for Plaintiff.

Geoffrey J. Michael, Murray R. Garnick, Arnold & Porter, LLP, Robert A. McCarter, III, J. Michael A. Carvin, Jones Day, Washington, DC, Michael K. Murray, Goodwin Procter, LLP, Thomas E. Peisch, Erin K. Higgins, Conn, Kavanaugh, Rosenthal, Peisch & Ford, LLP, Scott E. Erlich, Nutter, McClennen & Fish, LLP, David H. Sempert, Patricia A. Hartnett, Cornell & Gollub, Boston, MA, Harold K. Gordon, Traci L. Lovitt, Jones Day, New York, NY, Theodore M. Grossman, Jones Day, Cleveland, OH, for Defendant.

MEMORANDUM AND ORDER ON DEFENDANTS' MOTION TO DISMISS OR TRANSFER

STEARNS, D.J.

BACKGROUND

Plaintiff United Seniors Association, Inc. (United Seniors), undertook this litigation as a "private attorney general," a status authorized by the Medicare as Secondary Payer (MSP) law, 42 U.S.C. § 1395y(b)(3)(A). Defendants are manufacturers and sellers of tobacco products. United Seniors seeks, on behalf of the federal Medicare program, to recover medical expense reimbursements made by Medicare since August 4, 1999, to treat Medicare recipients for illnesses attributable to cigarette smoking.

United Seniors is a nationwide nonprofit "taxpayer protection" association claiming a membership of some 1.5 million older Americans. United Seniors states that its mission is to "safeguard the Social Security Trust Fund" and the "financial integrity of Medicare." Complaint ¶ 8. In its Complaint, United Seniors alleges that the defendants are self-insured MSP "primary plans" who have "battered" Medicare beneficiaries by exposing them to the addictive evils of nicotine.[1]

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[1] Although "battered" may seem an odd expression under the circumstances, the action is brought on a common-law theory of tort.

Defendants move to dismiss the Complaint on three grounds. First, they argue that they have never been found liable, nor have they ever assumed responsibility for the medical bills that United Seniors seeks to recover; second, they argue that United Seniors has no constitutional or statutory standing to bring this action; and third, that because United Seniors is in "privity" with the plaintiffs who brought suit in *Glover v. Philip Morris USA*, 380 F.Supp.2d 1279 (M.D.Fla.2005), it is collaterally estopped from relitigating the issue of whether defendants are "responsible or required" to make payments to Medicare.[2] The motion to dismiss was argued on June 29, 2006.

DISCUSSION

Medicare acts as a "secondary insurer" for older Americans.[3] If a beneficiary has primary medical insurance, the private insurer – and not Medicare – is the payor of first resort. Because the existence of primary coverage may not be known when a patient is treated, the MSP authorizes Medicare to make "conditional" payments on behalf of the primary plan insurer. 42 U.S.C. § 1395y(b)(2)(B)(i). "Primary plans"

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[2] In the alternative, defendants ask that this case be transferred to the Middle District of Florida to be consolidated with the *Glover* action.

[3] The mechanism by which Medicare acts as a secondary payer is thoroughly explained in *Mason v. American Tobacco Co.*, 346 F.3d 36, 38 (2d Cir.2003).

include group healthcare plans, "workmen's compensation law[s] or plan[s]," "liability insurance polic[ies] or plan[s]," and "self-insured plan[s]." 42 U.S.C. § 1395y(b)(2)(A)(ii). If Medicare makes a conditional payment on behalf of a primary plan that is "required or responsible . . . to make payment," Medicare may seek reimbursement from the primary plan. 42 U.S.C. § 1395y(b)(2)(B)(iii). *See Mason,* 346 F.3d at 38; *Glover v. Philip Morris USA*, 380 F.Supp.2d 1279, 1282 (M.D.Fla.2005).

MSP liability (double damages) attaches when a primary plan fails to make payment "promptly," that is, within 120 days of a claim being filed or a service being rendered. *See Glover,* 380 F.Supp.2d at 1290; 42 C.F.R. § 411.50(b). If the Medicare beneficiary on whose behalf a conditional payment is made has a tort claim, Medicare may seek reimbursement from the tortfeasor's insurance carrier, but only "after, and to the extent that, such carrier's liability under the [tortfeasor's] private policy for the services has been determined." 54 Fed.Reg. 41,716-01 at 41,727 (Oct. 11, 1989). *See also* 42 C.F.R. § 411.52(a). The same rules apply when the tortfeasor has internalized the insurance function by creating a "self-insured plan."

This case is a reprise of claims against the tobacco industry brought by the federal government in the late 1990's seeking to recoup Medicare costs incurred in treating smoking-related illnesses. *See United States v. Philip Morris Inc.*, 156 F.Supp.2d 1 (D.D.C.2000) (*Philip Morris II*); *see also Philip Morris*, 116 F.Supp.2d 131 (D.D.C.2000) (*Philip Morris I*).

These efforts by the government came largely to naught, with most courts rejecting the government's various theories of tobacco company liability. *See e.g., Philip Morris II*, 156 F.Supp.2d at 7-8: "The practical effect of the Government's conception of MSP liability would transform [the MSP], meant primarily for use against insurers, . . . into the very 'across-the-board procedural vehicle for suing tortfeasors' which this Court has already declared impermissible."

In *Mason v. American Tobacco Co.*, representatives of a nascent class of Medicare beneficiaries brought a private suit against the same defendants in this action based on the same failed interpretation of the MSP advanced by the government. The district court dismissed the case. *See Mason*, 212 F.Supp.2d 88 (E.D.N.Y.2002).[4] On appeal, the Second Circuit affirmed the district court on two separate grounds: (1) that the defendants' liability for Medicare costs had not been "established" for MSP purposes; and (2) that the defendants were not "self-insured plans" within the meaning of the MSP.[5] *See Mason,* 346 F.3d at 42-43.

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[4] The proposed class of Medicare beneficiaries in *Mason v. American Tobacco Co.*, were represented by the same counsel who represent United Seniors in this case.

[5] In *United States v. Baxter Int'l, Inc.*, 345 F.3d 866 (11th Cir.2003), the court held that a corporate defendant could be deemed a self-insured plan where it had created a mass tort settlement fund "assum[ing] responsibility and liability" for Medicare beneficiaries' tort related medical expenses. *Id.* at 895-897.

On the heels of the *Mason* decision, Congress enacted, and the President signed into law, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003(MMA), amending the MSP. The MMA broadened the definition of "primary plan" to include "[a]n entity that engages in a business, trade, or profession . . . if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part." The MMA also redefined the circumstances in which "primary plan" liability under the MSP attached.

> A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the beneficiary's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, *or by other means.*

42 U.S.C. § 1395y(2)(B)(ii) (emphasis added). Congress also declared that it intended the MMA amendments to apply retroactively. *See* H.R. 1 (108th Cong.) § 301(d)(1) (2003).

Under the MSP, a "primary plan . . . shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this subchapter with respect to an item or service if it is demonstrated that such primary plan *has or had a responsibility to make payment with respect to such item or service.*" 42 U.S.C. § 1395y(b)(2)(B)(ii) (emphasis added). A

"primary plan's" responsibility for reimbursing Medicare "may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release . . . of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means." *Id. See* 42 U.S.C. §§ 1395y(b)(2)(B)(iii) & (3)(A).

Defendants argue that the condition precedent for bringing an MSP claim is not the pendency of a disputed tort claim, but rather an "established obligation" to pay Medicare costs.

> Under the plain text of the statute, defendants are not subject to suit under the MSP unless and until they are found responsible for Medicare costs and they fail to reimburse Medicare within 120 days after that responsibility first arises. *42 C.F.R. § 411.50(b).* An alleged tortfeasor cannot be liable for failing to make a payment that it has no requirement to make. *See Glover,* 380 F.Supp.2d at 1295 ("[T]he new amendments . . . do not alter the principle, previously recognized, that MSP liability attaches only to an entity that is required or responsible to pay under a primary plan, a principle inapplicable to the alleged tortfeasors in this case." (citation and internal quotation marks omitted)). . . . It would allow a Medicare beneficiary injured by any product – ranging from a coffeemaker to asbestos – to bring a tort claim against the corporate manufacturer in federal court to recoup double damages. Because such a claim would be brought under the auspices of

> the MSP, it would be within the federal jurisdiction of this Court; no showing of diversity or jurisdictional amount would be required.

Defendants' Memorandum, at 14-15.

United Seniors maintains that neither the statute nor the regulatory history supports the defendants' "two-lawsuit" theory that no MSP reimbursement action may be brought without first obtaining a judgment against a defendant or some other form of legally binding obligation to pay.

> If Congress had intended that an MSP action could be brought only after a previous adjudication of third party responsibility, the legislation would have been written in the past perfect subjunctive tense – i.e., a primary plan would be required to reimburse Medicare only "if it *had been demonstrated* that such primary plan is responsible." Congress's decision to use the present subjunctive tense ("if it is demonstrated") conveys the idea that the demonstration of third-party liability need not have been accomplished before the MSP action can be pursued; it can occur during the MSP action itself.

Plaintiff's Opposition Memorandum, at 15. By way of analogy, United Seniors argues that a plaintiff suing for malicious prosecution need not establish malice in a separate lawsuit, nor must the false character of a claim under the federal False Claims

Act be independently proven before a qui tam lawsuit can be brought.[6]

> Even applying *ejusdem generis,* a judgment in an MSP action *is* a judgment (the statute says nothing about pre-existing), and so need not be shoe-horned into "other means." Read in this straightforward way, an MSP responsibility to pay can be demonstrated by an MSP judgment.

Id. at 19.

In *Glover,* relying on these same arguments, plaintiffs sought to recover smoking-related expenditures incurred by Medicare in Florida. The arguments were rejected by the district court, and after argument was heard on this motion, by the Eleventh Circuit on appeal. *See Glover v. Liggett Group, Inc.*, ___ F.3d ___, 2006 WL 2336587 (C.A.11 (Fla., Aug. 14, 2006). The Eleventh Circuit agreed with the district court that "**an alleged tortfeasor's responsibility for payment of a Medicare beneficiary's medical costs must be demonstrated *before* an MSP private cause of action for failure to reimburse Medicare can correctly be brought under** § 1395y(b)(3)(A)." Any contrary interpretation of the MSP would, according to the Eleventh Circuit, radically impact on the allocation of jurisdiction between

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[6] This is true, but somewhat irrelevant to an interpretation of a comprehensive and self-defining statute like the MSP.

the federal and state courts and on traditional considerations of due process

> **by creating a federal forum to litigate any state tort claim in which a business entity allegedly injured a Medicare beneficiary, without regard to diversity of citizenship or amount in controversy. Second, under Plaintiffs' interpretation, an alleged tortfeasor that is sued under the MSP (instead of under state tort law) could not contest liability without risking the penalty of double damages: defendants would have no opportunity to reimburse Medicare after responsibility was established but before the penalty attached. Third, Plaintiffs' proposed interpretation would allow individuals acting as private attorney generals to litigate the state tort liability of a defendant towards thousands of Medicare beneficiaries – as a predicate to showing MSP liability – without complying with class action requirements. We are confident that, if Congress intended such radical innovations in jurisdiction, federal-state relations, and tort liability, it would have more clearly expressed its intent.**

Glover, 2006 WL 2336587, (11th Cir.(Fla.)).[7] *See Gregory v. Ashcroft*, 501 U.S. 452, 460 (1991).

ORDER

Relying on the jurisprudential grounds and statutory reasoning expounded by the Eleventh Circuit in *Glover,* the court will *ALLOW* defendants' motion to dismiss the Complaint. The motion to transfer is *MOOT.*

SO ORDERED.

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[7] The court acknowledges the amicus brief filed on behalf of U.S. Senator Charles Grassley. While I found the brief informative, I agree with Judge Corrigan (to whom the same brief was presented), that its fundamental argument is inconsistent with the legislative history of the MSP. *Glover,* 380 F.Supp. at 1298. The court also acknowledges the letters written by the parties alerting the court to the encyclopedic opinion of Judge Kessler in *United States of America v. Phillip Morris,* 2006 WL 2380622 (D.D.C. Aug. 17, 2006) (Part 1); 2006 WL 2380632 (Part 2), 2006 WL 2380648 (Part 3), 2006 WL 2381449 (Part 4), 2006 WL 2380650 (Part 5), and 2006 WL 2380681 (Part 6). Given the enormous length of Judge Kessler's opinion, I cannot claim to have done more than skim its contents for a sighting of any findings that might be relevant to this case. As I can see none, there is no reason to delay this decision (as plaintiff suggests).

Medicare as Secondary Payer
42 U.S.C. § 1395y(b)

42 U.S.C.A. § 1395y. Exclusions from coverage and medicare as secondary payer

(b) Medicare as secondary payer

(1) Requirements of group health plans

(A) Working aged under group health plans

(i) In general

A group health plan –

(I) may not take into account that an individual (or the individual's spouse) who is covered under the plan by virtue of the individual's current employment status with an employer is entitled to benefits under this subchapter under section 426(a) of this title, and

(II) shall provide that any individual age 65 or older (and the spouse age 65 or older of any individual) who has current employment status with an employer shall be entitled to the same benefits under the plan under the same conditions as any such individual (or spouse) under age 65.

(ii) Exclusion of group health plan of a small employer

Clause (i) shall not apply to a group health plan unless the plan is a plan of, or contributed to by, an employer that has 20 or more employees for each working day in each of 20 or more calendar weeks in the current calendar year or the preceding calendar year.

(iii) Exception for small employers in multiemployer or multiple employer group health plans

Clause (i) also shall not apply with respect to individuals enrolled in a multiemployer or multiple employer group health plan if the coverage of the individuals under the plan is by virtue of current employment status with an employer that does not have 20 or more individuals in current employment status for each working day in each of 20 or more calendar weeks in the current calendar year and the preceding calendar year; except that the exception provided in this clause shall only apply if the plan elects treatment under this clause.

(iv) Exception for individuals with end stage renal disease

Subparagraph (C) shall apply instead of clause (i) to an item or service furnished in a month to an individual if for the month the individual is, or (without regard to entitlement under section 426 of this title) would upon application be,

entitled to benefits under section 426-1 of this title.

(v) "Group health plan" defined

In this subparagraph, and subparagraph (C), the term "group health plan" has the meaning given such term in section 5000(b)(1) of the Internal Revenue Code of 1986, without regard to section 5000(d) of Title 26.

(B) Disabled individuals in large group health plans

(i) In general

A large group health plan (as defined in clause (iii)) may not take into account that an individual (or a member of the individual's family) who is covered under the plan by virtue of the individual's current employment status with an employer is entitled to benefits under this subchapter under section 426(b) of this title.

(ii) Exception for individuals with end stage renal disease

Subparagraph (C) shall apply instead of clause (i) to an item or service furnished in a month to an individual if for the month the individual is, or (without regard to entitlement under section 426 of this title) would upon application be, entitled to benefits under section 426-1 of this title.

(iii) "Large group health plan" defined

In this subparagraph, the term "large group health plan" has the meaning given such term in section 5000(b)(2) of Title 26, without regard to section 5000(d) of Title 26.

(C) Individuals with end stage renal disease

A group health plan (as defined in subparagraph (A)(v)) –

(i) may not take into account that an individual is entitled to or eligible for benefits under this subchapter under section 426-1 of this title during the 12-month period which begins with the first month in which the individual becomes entitled to benefits under part A under the provisions of section 426-1 of this title, or, if earlier, the first month in which the individual would have been entitled to benefits under such part under the provisions of section 426-1 of this title if the individual had filed an application for such benefits; and

(ii) may not differentiate in the benefits it provides between individuals having end stage renal disease and other individuals covered by such plan on the basis of the existence of end stage renal disease, the need for renal dialysis, or in any other manner;

except that clause (ii) shall not prohibit a plan from paying benefits secondary to this subchapter when an individual is entitled to or eligible for benefits under this subchapter under section 426-1 of this title after the end of the 12-month period described in clause (i). Effective for items and services furnished on or after February 1, 1991, and before August 5, 1997,[1] (with respect to periods beginning on or after February 1, 1990), this subparagraph shall be applied by substituting "18-month" for "12-month" each place it appears. Effective for items and services furnished on or after August 5, 1997, (with respect to periods beginning on or after the date that is 18 months prior to such date), clauses (i) and (ii) shall be applied by substituting "30-month" for "12-month" each place it appears.

(D) Treatment of certain members of religious orders

In this subsection, an individual shall not be considered to be employed, or an employee, with respect to the performance of services as a member of a religious order which are considered employment only by virtue of an election made by the religious order under

[1] So in original. The comma probably should not appear.

section 3121(r) of the Internal Revenue Code of 1986.

(E) General provisions

For purposes of this subsection:

(i) Aggregation rules

(I) All employers treated as a single employer under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 shall be treated as a single employer.

(II) All employees of the members of an affiliated service group (as defined in section 414(m) of Title 26) shall be treated as employed by a single employer.

(III) Leased employees (as defined in section 414(n)(2) of Title 26) shall be treated as employees of the person for whom they perform services to the extent they are so treated under section 414(n) of Title 26.

In applying sections of the Internal Revenue Code of 1986 under this clause, the Secretary shall rely upon regulations and decisions of the Secretary of the Treasury respecting such sections.

(ii) Current employment status defined

An individual has "current employment status" with an employer if the individual is an employee, is the employer, or is associated with the employer in a business relationship.

(iii) Treatment of self-employed persons as employers

The term "employer" includes a self-employed person.

(F) Limitation on beneficiary liability

An individual who is entitled to benefits under this title and is furnished an item or service for which such benefits are incorrectly paid is not liable for repayment of such benefits under this paragraph unless payment of such benefits was made to the individual.

(2) Medicare secondary payer

(A) In general

Payment under this subchapter may not be made, except as provided in subparagraph (B), with respect to any item or service to the extent that –

(i) payment has been made, or can reasonably be expected to be made, with respect to the item or service as required under paragraph (1), or

(ii) payment has been made or can reasonably be expected to be made under a workmen's compensation law or plan of the United States or a State or under

an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance.

In this subsection, the term "primary plan" means a group health plan or large group health plan, to the extent that clause (i) applies, and a workmen's compensation law or plan, an automobile or liability insurance policy or plan (including a self-insured plan) or no fault insurance, to the extent that clause (ii) applies. An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.

(B) Repayment required

(i) Authority to make conditional payment

The Secretary may make payment under this subchapter with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with

the succeeding provisions of this subsection.

(ii) Primary plans

A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this subchapter with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means. If reimbursement is not made to the appropriate Trust Fund before the expiration of the 60-day period that begins on the date notice of, or information related to, a primary plan's responsibility for such payment or other information is received, the Secretary may charge interest (beginning with the date on which the notice or other information is received) on the amount of the reimbursement until reimbursement is made (at a rate determined by the Secretary in accordance with regulations of the

Secretary of the Treasury applicable to charges for late payments).

(iii) Action by United States

In order to recover payment made under this subchapter for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity. The United States may not recover from a third-party administrator under this clause in cases where the third-party administrator would not be able to recover the amount at issue from the employer or group health plan and is not employed by or under contract with the employer or group health plan at the time the action for recovery is initiated by the United States or for whom it provides administrative

services due to the insolvency or bankruptcy of the employer or plan.

(iv) Subrogation rights

The United States shall be subrogated (to the extent of payment made under this subchapter for such an item or service) to any right under this subsection of an individual or any other entity to payment with respect to such item or service under a primary plan.

(v) Waiver of rights

The Secretary may waive (in whole or in part) the provisions of this subparagraph in the case of an individual claim if the Secretary determines that the waiver is in the best interests of the program established under this subchapter.

(vi) Claims-filing period

Notwithstanding any other time limits that may exist for filing a claim under an employer group health plan, the United States may seek to recover conditional payments in accordance with this subparagraph where the request for payment is submitted to the entity required or responsible under this subsection to pay with respect to the item or service (or any portion thereof) under a primary plan within the 3-year period beginning on the date on which the item or service was furnished.

(C) Treatment of questionnaires

The Secretary may not fail to make payment under subparagraph (A) solely on the ground that an individual failed to complete a questionnaire concerning the existence of a primary plan.

(3) Enforcement

(A) Private cause of action

There is established a private cause of action for damages (which shall be in an amount double the amount otherwise provided) in the case of a primary plan which fails to provide for primary payment (or appropriate reimbursement) in accordance with paragraphs (1) and (2)(A).

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42 C.F.R. § 411.22 Reimbursement obligations of primary payers and entities that received payment from primary payers.

(a) A primary payer, and an entity that receives payment from a primary payer, must reimburse CMS for any payment if it is demonstrated that the primary payer has or had a responsibility to make payment.

(b) A primary payer's responsibility for payment may be demonstrated by –

(1) A judgment;

(2) A payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary payer or the primary payer's insured; or

(3) By other means, including but not limited to a settlement, award, or contractual obligation.

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42 C.F.R. § 411.23 Beneficiary's cooperation.

(a) If CMS takes action to recover conditional payments, the beneficiary must cooperate in the action.

(b) If CMS's recovery action is unsuccessful because the beneficiary does not cooperate, CMS may recover from the beneficiary.

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42 C.F.R. § 411.24 Recovery of conditional payments.

If a Medicare conditional payment is made, the following rules apply:

(a) Release of information. The filing of a Medicare claim by on or behalf of the beneficiary constitutes an express authorization for any entity, including State Medicaid and workers' compensation agencies, and data depositories, that possesses information pertinent to the Medicare claim to release that information to CMS. This information will be used only for Medicare claims processing and for coordination of benefits purposes.

(b) Right to initiate recovery. CMS may initiate recovery as soon as it learns that payment has been made or could be made under workers' compensation, any liability or no-fault insurance, or an employer group health plan.

(c) Amount of recovery.

(1) If it is not necessary for CMS to take legal action to recover, CMS recovers the lesser of the following:

(i) The amount of the Medicare primary payment.

(ii) The full primary payment amount that the primary payer is obligated to pay under this part without regard to any payment, other than a full primary payment that the primary payer has paid or will make, or, in

the case of a primary payment recipient, the amount of the primary payment.

(2) If it is necessary for CMS to take legal action to recover from the primary payer, CMS may recover twice the amount specified in paragraph (c)(1)(i) of this section.

(d) Methods of recovery. CMS may recover by direct collection or by offset against any monies CMS owes the entity responsible for refunding the conditional payment.

(e) Recovery from primary payers. CMS has a direct right of action to recover from any primary payer.

(f) Claims filing requirements.

(1) CMS may recover without regard to any claims filing requirements that the insurance program or plan imposes on the beneficiary or other claimant such as a time limit for filing a claim or a time limit for notifying the plan or program about the need for or receipt of services.

(2) However, CMS will not recover its payment for particular services in the face of a claims filing requirement unless it has filed a claim for recovery by the end of the year following the year in which the Medicare intermediary or carrier that paid the claim has notice that the third party is a primary plan to Medicare for those particular services. (A notice received during the last three months of a year is considered received during the following year.)

(g) Recovery from parties that receive primary payment. CMS has a right of action to recover its payments from any entity, including a beneficiary, provider, supplier, physician, attorney, State agency or private insurer that has received a primary payment.

(h) Reimbursement to Medicare. If the beneficiary or other party receives a primary payment, the beneficiary or other party must reimburse Medicare within 60 days.

(i) Special rules.

(1) In the case of liability insurance settlements and disputed claims under employer group health plans, workers' compensation insurance or plan, and no-fault insurance, the following rule applies: If Medicare is not reimbursed as required by paragraph (h) of this section, the primary payer must reimburse Medicare even though it has already reimbursed the beneficiary or other party.

(2) The provisions of paragraph (i)(1) of this section also apply if a primary payer makes its payment to an entity other than Medicare when it is, or should be, aware that Medicare has made a conditional primary payment.

(3) In situations that involve procurement costs, the rule of § 411.37(b) applies.

(j) Recovery against Medicaid agency. If a primary payment is made to a State Medicaid agency and that agency does not reimburse Medicare, CMS may reduce any Federal funds due the Medicaid agency (under title XIX of the

Act) by an amount equal to the Medicare payment or the primary payment, whichever is less.

(k) Recovery against Medicare contractor. If a Medicare contractor, including an intermediary or carrier, also insures, underwrites, or administers as a third party administrator, a program or plan that is primary to Medicare, and does not reimburse Medicare, CMS may offset the amount owed against any funds due the intermediary or carrier under title XVIII of the Act or due the contractor under the contract.

(l) Recovery when there is failure to file a proper claim –

(1) Basic rule. If Medicare makes a conditional payment with respect to services for which the beneficiary or provider or supplier has not filed a proper claim with a primary payer, and Medicare is unable to recover from the primary payer, Medicare may recover from the beneficiary or provider or supplier that was responsible for the failure to file a proper claim.

(2) Exceptions:

(i) This rule does not apply in the case of liability insurance nor when failure to file a proper claim is due to mental or physical incapacity of the beneficiary.

(ii) CMS will not recover from providers or suppliers that are in compliance with the requirements of § 489.20 of this chapter and can show that the reason they failed to file a proper claim is that

the beneficiary, or someone acting on his or her behalf, failed to give, or gave erroneous, information regarding coverage that is primary to Medicare.

(m) Interest charges.

(1) With respect to recovery of payments for items and services furnished before October 31, 1994, CMS charges interest, exercising common law authority in accordance with 45 CFR 30.13, consistent with the Federal Claims Collection Act (31 U.S.C. 3711).

(2) In addition to its common law authority with respect to recovery of payments for items and services furnished on or after October 31, 1994, CMS charges interest in accordance with section 1862(b)(2)(B)(i) of the Act. Under that provision –

(i) CMS may charge interest if reimbursement is not made to the appropriate trust fund before the expiration of the 60-day period that begins on the date on which notice or other information is received by CMS that payment has been or could be made under a primary plan;

(ii) Interest may accrue from the date when that notice or other information is received by CMS, is charged until reimbursement is made, and is applied for full 30-day periods; and

(iii) The rate of interest is that provided at § 405.378(d) of this chapter.

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42 C.F.R. § 411.26 Subrogation and right to intervene.

(a) Subrogation. With respect to services for which Medicare paid, CMS is subrogated to any individual, provider, supplier, physician, private insurer, State agency, attorney, or any other entity entitled to payment by a primary payer.

(b) Right to intervene. CMS may join or intervene in any action related to the events that gave rise to the need for services for which Medicare paid.

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42 C.F.R. § 411.37 Amount of Medicare recovery when a primary payment is made as a result of a judgment or settlement.

(a) Recovery against the party that received payment –

(1) General rule. Medicare reduces its recovery to take account of the cost of procuring the judgment or settlement, as provided in this section, if –

(i) Procurement costs are incurred because the claim is disputed; and

(ii) Those costs are borne by the party against which CMS seeks to recover.

(2) Special rule. If CMS must file suit because the party that received payment opposes CMS's recovery, the recovery amount is as set forth in paragraph (e) of this section.

(b) Recovery against the primary payer. If CMS seeks recovery from the primary payer, in accordance with § 411.24(i), the recovery amount will be no greater than the amount determined under paragraph (c) or (d) or (e) of this section.

(c) Medicare payments are less than the judgment or settlement amount. If Medicare payments are less than the judgment or settlement amount, the recovery is computed as follows:

(1) Determine the ratio of the procurement costs to the total judgment or settlement payment.

(2) Apply the ratio to the Medicare payment. The product is the Medicare share of procurement costs.

(3) Subtract the Medicare share of procurement costs from the Medicare payments. The remainder is the Medicare recovery amount.

(d) Medicare payments equal or exceed the judgment or settlement amount. If Medicare payments equal or exceed the judgment or settlement amount, the recovery amount is the total judgment or settlement payment minus the total procurement costs.

(e) CMS incurs procurement costs because of opposition to its recovery. If CMS must bring suit against the party that received payment because that party opposes CMS's recovery, the recovery amount is the lower of the following:

(1) Medicare payment.

(2) The total judgment or settlement amount, minus the party's total procurement cost.

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42 C.F.R. § 411.50 General provisions.

(a) Limits on applicability. The provisions of this subpart C do not apply to any services required because of accidents that occurred before December 5, 1980.

(b) Definitions.

Automobile means any self-propelled land vehicle of a type that must be registered and licensed in the State in which it is owned.

Liability insurance means insurance (including a self-insured plan) that provides payment based on legal liability for injury or illness or damage to property. It includes, but is not limited to, automobile liability insurance, uninsured motorist insurance, underinsured motorist insurance, homeowners' liability insurance, malpractice insurance, product liability insurance, and general casualty insurance.

Liability insurance payment means a payment by a liability insurer, or an out-of-pocket payment, including a payment to cover a deductible required by a liability insurance policy, by any individual or other entity that carries liability insurance or is covered by a self-insured plan.

No-fault insurance means insurance that pays for medical expenses for injuries sustained on the property or premises of the insured, or in the use, occupancy, or operation of an automobile, regardless of who may have been responsible for causing the accident. This insurance includes but is not limited to automobile, homeowners, and commercial plans. It is sometimes called "medical payments coverage", "personal injury protection", or "medical expense coverage".

Prompt or promptly, when used in connection with payment by a liability insurer means payment within 120 days after the earlier of the following:

(1) The date a claim is filed with an insurer or a lien is filed against a potential liability settlement.

(2) The date the service was furnished or, in the case of inpatient hospital services, the date of discharge.

Self-insured plan means a plan under which an individual, or a private or governmental entity, carries its own risk instead of taking out insurance with a carrier. This term includes a plan of an individual or other entity engaged in a business, trade, or profession, a plan of a non-profit organization such as a social, fraternal, labor, educational, religious, or professional organization, and the plan established by the Federal government to pay liability claims under the Federal Tort Claims Act. An entity that engages in a business, trade, or profession is deemed to have a

self-insured plan for purposes of liability insurance if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.

Underinsured motorist insurance means insurance under which the policyholder's level of protection against losses caused by another is extended to compensate for inadequate coverage in the other party's policy or plan.

Uninsured motorist insurance means insurance under which the policyholder's insurer will pay for damages caused by a motorist who has no automobile liability insurance or who carries less than the amount of insurance required by law, or is underinsured.

(c) Limitation on payment for services covered under no-fault insurance. Except as provided under §§ 411.52 and 411.53 with respect to conditional payments. Medicare does not pay for the following:

(1) Services for which payment has been made or can reasonably be expected to be made under automobile no-fault insurance.

(2) Services furnished on or after November 13, 1989 for which payment has been made or can reasonably be expected to be made under any no-fault insurance other than automobile no-fault.

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42 C.F.R. § 411.52 Basis for conditional Medicare payment in liability cases.

(a) A conditional Medicare payment may be made in liability cases under either of the following circumstances:

(1) The beneficiary has filed a proper claim for liability insurance benefits but the intermediary or carrier determines that the liability insurer will not pay promptly for any reason other than the circumstances described in § 411.32(a)(1). This includes cases in which the liability insurance carrier has denied the claim.

(2) The beneficiary has not filed a claim for liability insurance benefits.

(b) Any conditional payment that CMS makes is conditioned on reimbursement to CMS in accordance with subpart B of this part.

IN THE UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

UNITED SENIORS ASSOCIATION, INC., as a private attorney general, Plaintiff, v. PHILIP MORRIS USA, R.J. REYNOLDS TOBACCO COMPANY, BROWN & WILLIAMSON TOBACCO CORPORATION, individually and as the successor to THE AMERICAN TOBACCO COMPANY, LORILLARD TOBACCO COMPANY, INC., and LIGGETT GROUP, INC., Defendants.	Case No. 05-11623 RGS JURY TRIAL DEMANDED

COMPLAINT

THE NATURE OF THE CASE

1. Plaintiff, United Seniors Association, Inc., brings this action as a "private attorney general" pursuant to the private cause of action provisions of the Medicare as Secondary Payer ("MSP") statute, 42 U.S.C. § 1395y(b)(3)(A), seeking to recover for the Medicare program all the expenditures it made from August 4, 1999 to the present for the health care services rendered to Medicare's beneficiaries for the treatment of diseases attributable to cigarette

smoking, including, but not limited to, coronary heart disease, chronic obstructive pulmonary disease ("COPD"), lung cancer, emphysema, peripheral vascular disease, and atherosclerosis. This action does not seek to recover such Medicare expenditures made for health care services rendered in Florida for the treatment of diseases attributable to smoking the cigarettes of Philip Morris USA and the Liggett Group, Inc.

2. The MSP statute's function is straightforward: to relieve Medicare of the obligation to pay a beneficiary's medical expenses if payment for covered services has been or is reasonably expected to be made by someone else, called the "primary payer" or the "primary plan."

3. The defendants are corporations that engage in the business of manufacturing and selling almost all of the cigarettes purchased in this country. The defendants have operated their businesses pursuant to plans and arrangements by which they have taken out insurance with carriers who carry all or part of the risk of liability for torts resulting from the operation of the defendants' businesses, including torts resulting from smoking the defendants' cigarettes. As such, the defendants have liability insurance policies or plans that are "primary plans" within the meaning of the MSP statute. To the extent that the defendants have not taken out such liability insurance with carriers or such liability insurance is no longer in force, or to the extent that the liability insurance they have taken out with carriers does not provide payment for all the tort liability resulting from the

defendants' products, the defendants operate their businesses pursuant to plans and arrangements by which they carry their own risk of liability for such torts. As such, the defendants constitute self-insured liability plans that are "primary plans" within the meaning of the MSP statute.

4. The nicotine in cigarettes is an addictive drug. While the defendants were aware of this fact, their customers, including the Medicare beneficiaries who have suffered from or are suffering from diseases attributable to cigarette smoking, were not. Addiction is the key to the injury inflicted by the defendants' cigarettes because it is the prolonged use of cigarettes that commonly causes these diseases. The defendants not only intentionally concealed this addictive character of their cigarettes, but sought to discredit any information that might bring this addictiveness to light. At the same time, the defendants knowingly manipulated the addictiveness of their cigarettes to enhance its impact on their customers. The Medicare beneficiaries who have suffered from or are suffering from diseases attributable to smoking the defendants' cigarettes did not consent to being exposed to the addictive properties of the defendants' cigarettes. Consequently, the defendants are liable in tort, specifically battery, for the health care expenses of the Medicare beneficiaries who have suffered from or are suffering from diseases attributable to smoking the defendants' cigarettes.

5. As a result of this battery, the defendants are entities that have or had a responsibility under

the MSP statute to pay for the health care expenses of the Medicare beneficiaries necessitated by these diseases attributable to smoking the defendants' cigarettes; that is, their primary plans have failed to provide for primary payment or appropriate reimbursement to Medicare for such expenses. Accordingly, Medicare has been unlawfully and unnecessarily forced to pay enormous sums to diagnose and treat the diseases of Medicare beneficiaries attributable to smoking the defendants' cigarettes.

6. The role of the plaintiff as a "private attorney general" reflects the public importance of this case, especially to the Medicare program and its beneficiaries.

(a) In their 2005 Report, the Medicare Board of Trustees has reported that in 2004, 41.7 million people were covered by Medicare, which paid in that year alone $303 billion in benefits. Thus the importance of Medicare as a source of health care funding for tens of millions of Americans cannot be disputed.

(b) In a stark summary, the Public Trustees report that "Medicare's financial outlook has deteriorated dramatically over the past five years and is now much worse than Social Security's," In 2000, annual cash-flow deficits were projected to appear for Medicare's Hospital Insurance Trust Fund in 2010. In fact, as the Trustees note, that negative cash flow began in 2004, and by 2020 the Trust Fund will be bankrupt.

(c) The MSP regime was codified by Congress in the 1980s to reduce Medicare expenditures, a role all

the more essential with Medicare's financial status in such precarious straits. However, enforcement of the MSP regime, especially reimbursement of improper Medicare expenditures from other parties that should have been primary payers, has been disappointing. The Government Accounting Office ("GAO") has reported the lack of progress that has been made in collecting MSP debts, which "arise when Medicare covers expenses related to accidents, malpractice, workers' compensation, or other items not associated with group health plans that are subsequently determined to be the responsibility of another payer." According to the GAO, Medicare "lacks information on the total dollar amount of eligible debts not covered by its current referral instructions to Medicare contractors, and it has not developed a detailed plan or specific time frame for referring these debts." Moreover, Medicare does not even try to collect older MSP debts because it believes it is "not cost-effective to collect them." Indeed, the Justice Department simply does not have the resources to pursue these reimbursement cases on behalf of Medicare.

(d) Accordingly, Congress added the private right of action for double damages to the MSP statute "to save the government money by giving private citizens incentives to recover funds erroneously paid by Medicare." Even when Medicare itself lacks the information necessary to collect an MSP debt, that information nevertheless exists in the hands of each Medicare beneficiary who may be a tort victim and who, with the incentive provided by the double

damages provision of the MSP statute, can be motivated to sue as a "private attorney general" to collect that debt even if it is not cost-effective for Medicare to make the effort, and even if the more cumbersome federal bureaucracy is slow to take action.

(e) The MSP private right of action, like the *qui tam* provision of the False Claims Act, empowers private citizens to prosecute cases in which the federal government has overpaid. There have been hundreds of *qui tam* cases filed under the False Claims Act each year. In FY 2003, a record $2.1 billion was recovered under the False Claims Act (a 75% increase from FY 2002), and of that sum a staggering 70% was recovered not in suits brought by the government itself but in *qui tam* actions brought by citizens. This case – with reimbursements legally owing to Medicare of billions of dollars – suggests that the promise of the MSP private right of action for recovery of improper Medicare payments may be even greater than the impact of the *qui tam* statute.

(f) Indeed, Congress has long been committed to the MSP statute having exactly such an impact, as was underscored by the retroactive clarification of the MSP statute Congress enacted as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. Congress' clarification (retroactive to 1980 when "self-insured plan" was first added to the MSP statute) provides that "[a]n entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its

own risk (whether by a failure to obtain insurance or otherwise) in whole or in part."

(g) As the Chair of the Senate Finance Committee (which has jurisdiction over Medicare), Sen. Charles E. Grassley, explained, "when a Medicare beneficiary is injured by wrongful conduct of another entity, that entity's liability insurance or the entity itself, if it has no insurance, or it might be self-insured, is always required to pay first instead of having the taxpayers pay." The defendants here caused Medicare beneficiaries to be injured by their wrongful conduct, and this case seeks to recover from the defendants the money taxpayers wrongly had to pay for the medical care of those beneficiaries.

JURISDICTION AND VENUE

7. This Court has jurisdiction over this matter pursuant to 42 U.S.C. § 1395y(b)(3)(A), 28 U.S.C. § §1331, 1332, and 1367. Venue is proper in this district pursuant to 28 U.S.C. § 1391.

THE PARTIES

8. Plaintiff United Seniors Association, Inc. is a nonprofit, non-partisan, taxpayer protection organization with a nationwide network of over 1.5 million men and women, Founded in 1991, United Seniors Association, Inc. is dedicated to being a champion for taxpayers and expanding retirement and investment freedom, financial freedom, tax freedom, and health

freedom for Senior Americans, their children, grandchildren, and great-grandchildren. The work of the United Seniors Association, Inc. is greatly focused on protecting the vital interests of America's taxpayers, safeguarding the Social Security Trust Fund, creating Medicare and Social Security for the 21st Century, and creating effective and dynamic market solutions in public policy. The financial integrity of Medicare is clearly critical if taxpayers are to be protected and if Medicare is to remain an important source of affordable, quality health care for older Americans. In that regard, the United Seniors Association, Inc. is strongly committed to the governing principle of the MSP regime – which the taxpayers, through Medicare, should not function as the "deep pocket" to pay for the health care consequences of the wrongful acts of those who injure older Americans. By bringing this case as an MSP private attorney general as provided by Congress, the United Seniors Association, Inc. is thus acting to protect taxpayers, to preserve Medicare's financial integrity, and to vindicate the principle that Medicare is not intended to act as the "insurer" for those who injure Medicare's beneficiaries.

9. Defendant Philip Morris USA is a Virginia corporation with its principal place of business at 120 Park Avenue, New York, New York. At all relevant times, Philip Morris manufactured, advertised, and sold cigarettes, including Philip Morris, Merit, Cambridge, Collector's Choice, Commander, Marlboro, Benson & Hedges, Virginia Slims, Alpine, Dunhill,

English Ovals, Galaxy, Players, Saratoga, Basic, Bristol, Bucks, Chesterfield, Lark, L&M, B&H Menthols, and Parliament cigarettes, throughout the United States.

10. Defendant R.J. Reynolds Tobacco Company ("RJR" or "Reynolds") is a Delaware corporation with its principal place of busi ıess at 401 North Main Street, Winston-Salem, North Carolina. At all relevant times, RJR manufactured, advertised, and sold cigarettes, including Camel, Vantage, Now, Doral, Winston, Sterling, Magna, Monarch, More, Century, Bright Rite, Eclipse, and Salem cigarettes, throughout the United States.

11. Defendant Brown & Williamson Tobacco Corporation ("B&W") is a Delaware corporation with its principal place of business at 200 Brown & Williamson Tower, Louisville, Kentucky. At all relevant times, B&W manufactured, advertised, and sold cigarettes, including Kool, Raleigh, Barclay, BelAir, Capri, Richland, Laredo, Eli Cutter, GPC, GOC Lights, and Viceroy cigarettes throughout the United States. As a result of its acquisition of American Tobacco Company, B&W has succeeded to the liabilities of American Tobacco either by operation of law, or as a matter of fact. At all relevant times, American Tobacco manufactured, marketed, and sold cigarettes, including, Lucky Strike, Pall Mall, Tareyton, American, Malibu, Montclair, Newport, Misty, Iceberg, Silk Cut, Silva Thins, Sobrania, Bull Durham, and Carlton cigarettes, throughout the United States.

12. Defendant Lorillard Tobacco Company ("Lorillard") is a Delaware corporation with its principal place of business at 714 Green Valley Road, Greensboro, North Carolina. At all relevant times, Lorillard manufactured, advertised, and sold cigarettes, including Old Gold, Kent, Triumph, Satin, Maverick, Max, Spring, Newport and True cigarettes, throughout the United States.

13. Defendant Liggett Group, Inc. (f/k/a Liggett & Myers) is a Delaware corporation with its principal place of business at 100 Maple Lane, Mebane, North Carolina. At all relevant times, Liggett manufactured, advertised, and sold cigarettes, including Chesterfield, Decade, L & M, Pyramid, Dorado, Eve, Stride, Generic and Lark cigarettes, throughout the United States.

GENERAL ALLEGATIONS

A. THE MEDICARE AS SECONDARY PAYER REGIME

14. Under the Medicare program, the federal government pays for certain health care expenses of the aged (persons over 65 years old), the disabled, and persons suffering from end stage renal disease.

15. From its inception in 1965 until 1980, Medicare generally acted as the primary payer for all covered health care services rendered to eligible beneficiaries. That is, Medicare was the payer of first resort, even where some other entity might have been legally obligated to pay for the health care expenses

in a particular case. The sole exception up to 1980 was where payment for the health care services had been made or could "reasonably be expected to be made" under a state or federal workers' compensation scheme. In such a case, any Medicare payment for the services was conditioned on reimbursement from the involved workers' compensation plan.

16. Beginning in 1980, in response to burgeoning expenditures, Congress enacted a series of amendments now known collectively as the Medicare as Secondary Payer ("MSP") statute. The MSP statute was designed to reduce Medicare's obligation to make primary payment for covered services – and so conserve the dwindling Medicare Trust Funds – when another person or entity had a legal obligation to provide or pay for health care services needed by a Medicare beneficiary.

17. In general, under the terms of the MSP statute, Medicare is a secondary payer to two groups of entities: a) entities who have "a responsibility to make payment" for a Medicare beneficiary's health care costs because of a legal obligation voluntarily assumed, and b) entities who have "a responsibility to make payment" for a Medicare beneficiary's health care costs because of a legal obligation imposed by operation of law. In either case, any Medicare payment already made must be reimbursed by the entity that legally has the "responsibility to make payment," that is, where that entity has, or is, a "primary plan" that should have paid for the medical expense before Medicare.

18. A "primary plan" in the context of a legal obligation to pay medical expenses that is voluntarily assumed mainly refers to the health care coverage provided to employees as a benefit of their employment. That is, when an employer establishes a "group health plan" to pay for certain medical expenses of employees and their families, that group health plan is a "primary plan" under the MSP statute and must pay before Medicare on behalf of the employer.

19. A "primary plan" in the context of a legal obligation to pay medical expenses that is imposed by operation of law includes "a workmen's compensation law or plan, an automobile or liability insurance policy or plan (including a self-insured plan) or no fault insurance."

20. The MSP statute expressly provides that lain entity that engages in a business, trade, or profession shall be deemed to have a self insured plan if it carries its own risk (whether by a failure to obtain insurance or otherwise) in whole or in part."

21. The Centers for Medicare and Medicaid Services of the Department of Health and Human Services ("CMS"), formerly known as the Health Care Financing Administration ("HCFA"), the agency to whom Congress has delegated the responsibility to administer and interpret the MSP statute, has by lawful rulemaking provided that "'[p]lan' means any arrangement, oral or written, by one or more entities, to provide health benefits or medical care or assume legal liability for injury or illness."

22. CMS has by lawful rulemaking also provided that "'[s]elf-insured plan' means a plan under which an individual, or a private or governmental entity, carries its own risk instead of taking out insurance with a carrier."

23. Reflecting the remedial purpose of the MSP statute, CMS has further provided by lawful rulemaking that a "liability insurance payment" that should be primary to Medicare includes out-of-pocket payments made by an entity that carries liability insurance or is covered by a self insured plan. CMS recognized that such out-of-pocket payments might be made to avoid reporting an incident to a liability insurer, to pay a required deductible, or for other reasons. CMS expressly concluded that it was not consistent with the MSP statute to allow such payments to escape the mandate of the MSP statute.

24. Thus, a "self insured plan" within the meaning of the MSP statute and the governing regulations includes a corporation that has decided not to buy insurance for the legal liabilities or obligations that might be imposed on it, whether or not that decision is written down, and whether or not the corporation has established reserves to cover such liabilities or obligations.

25. The MSP statute provides no limitation on the kind of "liability" that might create an obligation to pay for the health care expenses of a Medicare beneficiary, and so makes the entity on whom such liability has been imposed a payer primary to

Medicare. CMS has by lawful rulemaking provided that "'[l]iability insurance' means insurance (including a self-insured plan) that provides payment based on legal liability for injury or illness or damage to property."

26. To help enforce compliance with the MSP statute and to assure that Medicare would not improperly pay for health care costs that were lawfully the responsibility of other entities like the defendants here, Congress authorized private parties like the plaintiff to bring suit for damages against entities, like these defendants, which have not properly paid primary for the health care costs of Medicare beneficiaries. In the MSP statute, Congress expressly required recovery in such a private action of damages in an amount double the expenditures of Medicare that should have been paid by such primary plans.

27. Under the MSP statute, the liability of a primary plan to reimburse Medicare can be demonstrated in an almost unlimited variety of ways. The MSP statute provides that liability "may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payments for items or services included in a claim against the primary plan or the primary plan's insured, ***or by other means***." (Emphasis added.) Thus, MSP liability based on an alleged tort may be established by proving the tort in an MSP reimbursement action.

B. The Defendant Corporations Are Primary Plans

28. On information and belief, each of the defendants has or had a liability insurance policy or plan (including a self-insured plan), within the meaning of the MSP statute, that covers liability to Medicare beneficiaries for the health care services required by their tobacco-related illnesses.

29. Insurance in any amount, however, cannot limit the liability the law might impose, and so the purchase of insurance does not fully protect the defendants or their assets from the liability that might be imposed, particularly where, as here, the intentionally wrongful conduct of the defendants is at issue. As a result, even a defendant which had purchased insurance from a third party is self insured to the extent that insurance does not fully cover a liability imposed by law.

30. In addition, some defendants at various times obtained insurance under the best terms they could, such as one policy under which defendant Philip Morris retained the risk of $1 million for each occurrence, with an overall cap on the liability insured of $10 million. At other times, the cost of insurance was, from the perspective of some of the defendants, prohibitively expensive in light of what they saw to be their risks, compared to what insurance underwriters saw as the defendants' risks.

31. To the extent that the defendants are not insured for the liability claimed in this action, they are entities "that engage[] in a business, trade, or profession" which "carr[y their] own risk (whether by a failure to obtain insurance or otherwise)," and so "are deemed to have a self-insured plan" under the express terms of the MSP statute.

32. In addition, there is significant other evidence that the defendants are self-insured plans by virtue of their *ex ante,* deliberate choice to carry the risk of liability for tobacco-related illnesses, including the following:

(a) By the early 1950s, scientific researchers were publishing findings that indicated a relationship between cigarette smoking and various illnesses, including lung cancer. As early as 1954, this growing scientific knowledge triggered litigation brought to hold the defendants liable for tobacco-related illnesses. Since that time, the pace of litigation has increased, while regulatory and legislative bodies have taken a variety of actions addressing tobacco-related illnesses. For example, in 1964, the Surgeon General of the United States declared cigarettes to be a health hazard.

(b) The executives of the defendants, and others in their employ, were, and continue to be, fully aware of the significant risk that the defendants would be held legally liable for the injury or illness caused by their cigarettes.

(c) The executives of the defendants had and continue to have fiduciary duties to the shareholders of the defendant corporations to make prudent arrangements to protect their corporations from the legal liability to which their cigarettes expose them. Such arrangements could include the purchase of insurance to cover, at least in part, the liability they might face. However, the risks involved have made many insurers reluctant to write liability insurance for defendants, and, where they did so, often insurers required a high deductible and a cap on the overall amount insured.

(d) Knowing the risks of legal liability that their cigarettes generated, the defendants made business decisions to continue to produce and market cigarettes, while vigorously contesting every case brought against them seeking to impose legal liability for tobacco-related illnesses.

(e) Accordingly, the defendants have deliberately chosen and planned to self-insure for risks of product liability and other tort claims inherent in their business, that is, they have planned to pay such claims from self-insured funds or retained earnings.

(f) The defendants have admitted that they have specifically planned *ex ante* to self-insure. Thus, for example, in a June 17, 1963 letter, William R. Lybrook of R.J. Reynolds responded to the inquiry of a current or prospective Reynolds shareholder as follows:

> This is to acknowledge your recent letter in which you inquired as to whether this Company has products liability insurance.
>
> We have never carried such insurance but have chosen to be self-insurers in this field.

(g) Some time after the 1963 letter quoted above, defendant R.J. Reynolds apparently did carry products liability insurance, and then chose to again become self-insured. As the company itself explained in its May 30, 1991 10-K:

> RJRN previously had maintained product liability insurance covering certain of these tobacco-related legal actions, proceedings and claims. As of April 13, 1990, RJRN became wholly self-insured for existing tobacco-related litigation risks.

(h) In 1999, Seth Moscowitz, a representative of R.J. Reynolds, "asserted that R.J. Reynolds Tobacco was self-insured" and explained that "product hazard exclusions" and "health hazard exclusions" have existed in their outside insurance policies for decades. Dan Lonkevich, *Fed's Tobacco Suit Might Prompt Ins. Claims,* NATIONAL UNDERWRITER, PROPERTY & CASUALTY/RISK & BENEFITS MANAGEMENT 42 (September 27, 1999).

(i) Similarly, "A spokesman told [World Insurance Report] that Brown & Williamson's product liability insurance exclusion *and consequent self-insurance arrangement* extends to legal costs." *Kicking Butts,*

WORLD INSURANCE REPORT (April 4, 1997). A spokesman for Brown & Williamson's parent BAT had earlier told the same publication that "like most tobacco companies, BAT's tobacco product liability is entirely self-insured." *Tobacco Makers Concede Over Litigation,* WORLD INSURANCE REPORT (February 21, 1997).

(j) The defendants have routinely admitted in reports filed with the federal government that they planned to rely on their own cash flows or retained earnings to fund their obligations in the event of liability. For instance, Philip Morris has stated: "It is possible that the Company's results of operations or cash flows could be materially affected by an ultimate unfavorable outcome of certain pending litigation. Management believes, however, that the ultimate outcome of all pending litigation should not have a material adverse effect on the Company's financial position." Philip Morris, Inc., 10-K, at 23 (Dec. 31, 1996).

(k) The Liggett Group Inc. has similarly stated, "it is possible that Liggett's financial position, results of operations and cash flows could be materially adversely affected by an ultimate unfavorable outcome in any of such pending litigation," Liggett Group Inc., 10-K, at 19 (Dec. 31, 1996).

(l) As far back as 1986 it was reported that tobacco "industry sources say the companies are now self-insuring," as "the cost of liability insurance has 'gone through the roof,' according to one tobacco

marketer." Nancy Giges, *Marketers Feel Product Liability Pressure; Risks Crimp Launch of New Items,* ADVERTISING AGE (May 12, 1986).

(m) Over a dozen years ago it had already become well-known in the insurance industry that "[p]roduct liability insurance covering health risk has been largely unavailable to most cigarette makers for roughly a decade, and several large companies now self-insure their product exposures." Douglas McLeod, *Tobacco Award Raises Insurance Questions,* BUSINESS INSURANCE (June 20, 1988).

(n) The prevailing practice in the tobacco industry to have self-insurance plans for liability coverage is evident from the statements of other entities involved in the cigarette business. For example, Core Mark International, Inc. is a distributor of various consumer goods, including cigarettes. As it pointed out in a prospectus filed with the SEC, it "is particularly dependent on the leading producers of cigarettes," which, as of 1997, included RJR, Philip Morris, and Brown & Williamson. Core Mark International, Inc., Prospectus Filed Pursuant to Rule 424(B)(1), at 16 (filed Jan. 10, 1997). In its Prospectus, Core Mark went on to explain:

> In light of the claimed health risks related to the use of cigarettes and other tobacco products, there can be no assurance that product liability claims will not be asserted against the tobacco industry or the Company in the future. Such lawsuits, if asserted against the tobacco industry or the

> Company and adversely determined, could have a material adverse effect on the Company's business and financial position. The Company carries general liability insurance, but *self-insures against liability in respect of health-related claims, which management believes is consistent with industry practice.*

Id. at 18 (emphasis added).

(o) The defendants' choice to pay liability claims from their cash flows or retained earnings, that is, to carry their own risk of legal liability for tobacco-related illnesses rather than taking out insurance with a carrier, relies in part on behavior patterns of consumers that indicate that increases in the price of cigarettes will not significantly decrease the volume of purchases of these products (in economics parlance, price-inelasticity), evidencing a peculiarly stable demand due to the addiction of customers and the effectiveness of massive advertising; and on a sophisticated body of knowledge that has been developed to estimate the liability risks they carry.

(p) Defendant Philip Morris illustrated how this mechanism works in practice in its 1998 10-K, in which it detailed that "[o]perating companies' [or company's] income for 1998 decreased . . . due primarily to higher tobacco-related settlement charges ($1.9 billion) . . . partially offset by price increases, net of cost increases ($1.8 billion)." Philip Morris, Inc., 10-K, at 27 (March 18, 1999).

33. As entities that engage in a business, trade, or profession, the defendants have self-insured plans and are primary plans within the meaning of the MSP statute if they simply have failed to obtain insurance for their tort liabilities, for whatever reasons or even lack of reasons. However, the defendants surpass that basic statutory threshold because they have adopted deliberate, *ex ante* plans to carry their own risk of tort liability, and so have adopted plans of self-insurance and are primary plans within the meaning of the MSP statute.

C. The Defendants Are Liable in Tort for the Tobacco-Related Illnesses of Medicare Beneficiaries.

1. Defendants Concealed, Denied, and Manipulated the Addictive Properties of Their Cigarettes.

34. In the latter half of the twentieth century, some 10 million Americans were killed by tobacco-related illnesses. As the Surgeon General confirmed in a report on the health consequences of smoking issued in 2004, "tobacco use remains the leading preventable cause of disease and death in the United States, causing approximately 440,000 deaths each year and costing approximately $157 billion in annual health-related economic losses." It has been estimated that the medical expenses needed to treat diseases attributable to smoking totaled approximately $75.5 billion per year between 1995 and 1999.

35. Diseases attributable to smoking the defendants' cigarettes include coronary heart disease, COPD, peripheral vascular disease, lung cancer, emphysema, atherosclerosis, leukemia, and cancers of the larynx, oral cavity, esophagus, pancreas, bladder, kidney, stomach, and cervix.

36. Cigarettes contain nicotine, which, among other effects, activates areas of the brain that are involved in producing feelings of pleasure and reward. At the same time, nicotine causes physical dependence and a withdrawal syndrome after abstinence from it. Nicotine thus is an addictive drug. The addictive nature of nicotine is directly related to the harm caused by cigarettes, because the health risks of smoking increase with prolonged use. The primary factor that prevents cigarette smokers from quitting smoking is their addiction to nicotine and their need for continuing intake of nicotine to avoid nicotine withdrawal.

37. The defendants and their agents have long known that nicotine is a powerful pharmacological agent – that is, a drug – with significant psychoactive effects. Most importantly for purposes of this action, defendants have long recognized that nicotine is addictive, and that addiction is what preserves the market for cigarettes and ensures their profits.

38. In contrast, the public at large has not been aware of the addictive properties of nicotine, and has believed that smoking and – most importantly for the health consequences of smoking – *continuing* to

smoke are largely matters of choice for which the individual is responsible. Most beginning smokers – particularly youngsters – falsely believe that they will be able to quit after smoking for a few years and thereby avoid the illnesses caused by smoking.

39. The defendants not only have been fully aware of this popular misconception of the addictive properties of nicotine; they have sought to perpetuate it by concealing the facts concerning nicotine's addictiveness thus rendering their product dangerously defective. Indeed, the defendants have deliberately understood and manipulated the addictive properties of nicotine in their cigarettes to undermine the ability of consumers to freely choose to refrain from smoking. The defendants have consciously pursued a clandestine business strategy that relies on creating and maintaining a market of captive consumers by virtue of the defendants' control over, and manipulation of, the nicotine in their cigarettes.

40. The defendants have understood nicotine's addictive properties since at least the early 1960s. More than 30 years ago, a report was completed for one of the defendants that specifically addressed the mechanism of nicotine addiction in smokers. The researchers concluded that chronic intake of nicotine, such as that which occurs in regular cigarette smokers, creates a need for ever-increasing levels of nicotine to maintain the desired action: "[u]nlike other dopings, such as morphine, the rate of increasing demand for greater dose levels is relatively slow for nicotine." The report continues:

> A body left in this unbalanced state craves for renewed drug intake in order to restore the physiological equilibrium. This unconscious desire explains the addiction of the individual to nicotine.

41. Forty three years ago, in 1959, the research department of Philip Morris stated the fact of the matter quite baldly: "Why do people smoke? . . . Addiction."

42. Lorillard similarly noted: "The consensus of opinion derived from a review of the literature on the subject indicates the most probable reason for the addictive properties of the smoke is nicotine."

43. In 1962, Sir Charles Ellis, a scientific advisor to the board of directors of BAT Industries, asserted in a meeting attended by Browne & Williamson representatives, that "smoking is a habit of addiction." Similarly, a year later Brown & Williamson general counsel Addison Yeaman pointed out that "nicotine is addictive," and concluded, logically, "We are, then, in the business of selling nicotine, an addictive drug." In the early 1980s researchers at Brown & Williamson echoed the point: "Nicotine is the addicting agent in cigarettes."

44. Similarly, Reynolds, understanding the importance of retaining sufficient nicotine to maintain dependence on its so-called "low tar/low nicotine" cigarettes, internally proposed in 1971 that the company undertake research into determining more exactly the "habituating level of nicotine." Developing

their understanding of the addictive attributes of nicotine became a key effort for the defendants, as was reflected in a 1980 memorandum from a Philip Morris official:

> ***Nicotine is a powerful pharmacological agent*** with multiple sites of action ***and may be the most important component of cigarette smoke. Nicotine and an understanding of its properties are important to the continued well being of our cigarette business*** since this alkaloid has been cited often as the reason for smoking and theories have been advanced for nicotine titration by the smoker. Nicotine is known to have effects on the central and peripheral nervous system as well as influencing memory, learning, pain perception, response to stress and level of arousal.

(Emphasis added.)

45. Much of the defendants' inquiries into the attributes of nicotine reflected an appreciation of the role of nicotine in creating new consumers of the defendants' cigarettes. For example, in 1974, Philip Morris researchers began a study designed to test their theory that hyperkinetic children take up smoking in adolescence because nicotine may perform the same pharmacological function as prescription medications used to treat hyperkinesis:

> It has been found that amphetamines, which are strong stimulants, have the anomalous effect of quieting these children down . . .

> Many children are therefore regularly administered amphetamines throughout grade school years. . . . ***We wonder whether such children may not eventually become cigarette smokers in their teenage years as they discover the advantage of self-stimulation via nicotine.*** We have already collaborated with a local school system in identifying some such children in the third grade.

(Emphasis added)

46. The commercial value of the addictive attributes of nicotine – that is, the properties of their cigarettes that help to create a captive market – were not lost on the defendants. For example, a 1971 secret internal report distributed to Philip Morris executives showed that tobacco executives knew the powerfully addictive nature of nicotine in cigarettes. The report studied persons who had tried to stop smoking and concluded that only 28 percent of those who tried to quit were still non-smokers eight months later:

> Even after eight months quitters were apt to report having neurotic symptoms, such as feeling depressed, being restless and tense, being ill-tempered, having a loss of energy, being apt to doze off. They were further troubled by constipation and weight gains which averaged about five pounds per quitter . . . This is not the happy picture painted by the Cancer Society's anti-smoking commercial which shows an exuberant couple leaping into the air and kicking their heels with

> joy because they've kicked the habit. A more appropriate commercial would show a restless, nervous, constipated husband bickering viciously with his bitchy wife who is nagging him about his slothful behavior and growing waistline.

47. As one presenter at a tobacco company conference summed up the results of studies of smokers who attempted to quit: "Although intentions and attempts to quit are relatively high (80-40% of smokers [in a given year]), the actual success rate of quitting is relatively low and stable."

48. Notwithstanding the facts concerning the addictiveness of nicotine established by the defendants' own studies, the defendants concealed their research and continued to deny the addictiveness of nicotine.

49. For example, a 1977 Philip Morris study on the withdrawal effects of nicotine was permitted to proceed only if the results were favorable. If not, as a Philip Morris researcher explained, "we will bury it."

50. For example, an internal 1978 Brown & Williamson memorandum discussed the addictiveness of nicotine and characterized nicotine as a poison, while noting that most consumers were unaware of this: "Very few consumers are aware of the effects of nicotine, i.e., its addictive nature and that nicotine is a poison . . . [H]ardly any consumers use nicotine numbers as a basis for their purchase."

51. For example, in March 1980, a Philip Morris scientist produced an internal memorandum discussing company research into the pharmacology of nicotine. The research was "aimed at understanding that specific action of nicotine which causes the smoker to repeatedly introduce nicotine into his body." The internal memorandum noted that it was "a highly vexatious topic" that company lawyers did not want to become public because nicotine's drug properties, if known, would support regulation of tobacco by the federal Food and Drug Administration. Consequently, the memorandum observed, "[o]ur attorneys . . . will likely continue to insist on a clandestine effort in order to keep nicotine the drug in low profile."

52. For example, in the early 1980s, Philip Morris hired Victor DeNoble and Paul Mele to study the effects of nicotine on the behavior of rats and to research and test potential nicotine analogues. DeNoble and Mele's research demonstrated that nicotine was addictive and that, in terms of addictiveness, "nicotine looked like heroin." In August 1983, Philip Morris ordered DeNoble to withdraw a research paper on nicotine that had already been accepted for publication after full peer review by the respected journal, PSYCHOPHARMACOLOGY. Less than a year later, Philip Morris abruptly closed DeNoble's research lab. Philip Morris executives threatened DeNoble and Mele with legal action if they published or talked about their nicotine research. Their research animals were killed, the equipment was

removed, and all traces of the former lab were eliminated.

53. For example, in 1988, when the Surgeon General concluded, based on non-industry research, that nicotine is addictive, agents of the defendants disputed that conclusion, saying that "claims that cigarettes are addictive contradict common sense. . . . The claim that cigarette smoking causes physical dependence is simply an unproven attempt to find some way to differentiate smoking from other behaviors."

54. For example, in a 1992 pamphlet, Philip Morris claimed, "Those who term smoking an addiction do so for ideological – not scientific – reasons."

55. As late as 1994, in an appearance before Congress, the chief executive officers of the defendant corporations were asked by Rep. Ron Wyden: "Do you believe nicotine is not addictive?" Under oath, they replied:

> William Campbell (Philip Morris): "I believe that nicotine is not addictive, yes."
>
> James Johnston (Reynolds): "Congressman, cigarettes and nicotine clearly do not meet the classic definition of addiction."
>
> Andrew Tisch (Lorillard): "I believe that nicotine is not addictive."
>
> Edward Horrigan (Liggett): "I believe that nicotine is not addictive."

> Thomas Sandefur (Brown & Williamson): "I believe that nicotine is not addictive."
>
> Donald Johnson (American Tobacco): "And I, too, believe that nicotine is not addictive."

56. At the same time that they were denying the addictiveness of nicotine, the defendants not only knowingly continued to produce and market cigarettes with the addicting properties of nicotine, but they were developing and using highly sophisticated technologies designed to deliver nicotine to smokers in ways intended to create and sustain addiction in the vast majority of individuals who smoke regularly. This manipulation of the nicotine content of cigarettes is achieved through selective breeding and cultivation of plants for nicotine content, and careful tobacco leaf purchasing and blending plans. The manipulation of nicotine delivery (that is, the amount of nicotine absorbed by the smoker) is achieved by various design and manufacturing techniques. As a 1973 internal document from the R.J. Reynolds Tobacco Company explained:

> Methods which may be used to increase smoke pH and/or nicotine "kick" include: (1) increasing the amount of (strong) burley in the blend, (2) reduction of casing sugar used on the burley and/or blend, (3) use of alkaline additives, usually ammonia compounds, to the blend, (4) addition of nicotine to the blend, (5) removal of acids from the blend, (6) special filter systems to remove acids from or add alkaline materials to the smoke, and (7) use of high air dilution filter

> systems. Methods 1-3, in combination, represent the Philip Morris approach, and are under investigation [by Reynolds].

57. Common among the chemical manipulations of tobacco to enhance the effect of nicotine is the use of ammonia. As a handbook from Brown & Williamson explains:

> Ammonia, when added to a tobacco blend, reacts with the indigenous nicotine salts and liberates free nicotine. As a result of such change, the ratio of extractable nicotine to bound nicotine in the smoke may be altered in favor of extractable nicotine. As we know, extractable nicotine contributes to impact in cigarette smoke and this is how ammonia can act as an impact booster.

58. Thus the denial and concealment of the addictiveness of nicotine is a central element of this case, at the core of defendants' tortious conduct. As a 1980 memorandum from the industry's Tobacco Institute conceded, "We can't defend continued smoking as 'free choice' if the person was addicted."

59. However, at least one defendant, Philip Morris, has now abandoned that strategy of denial and concealment of which it was a part for so many decades, coinciding with its support for legislation, now pending in Congress, which would provide for FDA regulatory authority over tobacco products. While Philip Morris states that such regulation would provide for "greater consistency in tobacco policy," and "more predictability for the tobacco industry," other

observers conclude that "selling cigarettes under government supervision would improve its public relations and legal atmosphere and would enable it to roll out 'reduced risk' cigarettes with the apparent approval of government scientists."

60. On its website, Philip Morris now says, "We agree with the overwhelming medical and scientific consensus that cigarette smoking is addictive."

61. No longer does Philip Morris dismiss the Surgeon General's warnings about the health effects and addictiveness of cigarette smoking as ideologically motivated, but describes the Surgeon General as "the nation's leading spokesperson on matters of public health," and the Philip Morris website provides a direct link to the very Surgeon General Report on nicotine addictiveness it sought to discredit.

62. The Philip Morris website also provides a direct link to the Centers for Disease Control ("CDC") website, which emphasizes, "Nicotine is a very addictive drug. For some people, it can be as addictive as heroin or cocaine."

63. Philip Morris now "agree[s] with the overwhelming medical and scientific consensus that cigarette smoking causes lung cancer, heart disease, emphysema and other serious diseases in smokers."

2. Defendants' Conduct Is Tortious

64. The risk of a cigarette smoker contracting a disease attributable to cigarette smoking greatly increases with prolonged use of cigarettes.

65. Smoking cigarettes is addictive.

66. The addictive properties of cigarettes cause or significantly contribute to the prolonged use of cigarettes.

67. The addictive properties of smoking cigarettes are caused by the nicotine in or added to the tobacco.

68. The addictive properties of the defendants' cigarettes pose a hazard distinct from the direct physical dangers of smoking.

69. At all relevant times, the defendants were aware of the addictive quality of the nicotine in their cigarettes.

70. At all relevant times, the defendants attempted to manipulate the levels of nicotine in their cigarettes to maintain or increase the addictive properties of their cigarettes.

71. At all relevant times, the defendants denied and attempted to conceal the addictive properties of the nicotine in their cigarettes rendering them dangerously defective products.

72. The exposure of a person to the addictive properties of nicotine in the defendants' cigarettes

constitutes a harmful or offensive contact with that person.

73. The defendants intended to cause the exposure of the persons who became Medicare beneficiaries to the addictive properties of nicotine in the defendants' cigarettes, that is, the defendants intended to cause this harmful or offensive contact with those persons.

74. This harmful or offensive contact with persons who became Medicare beneficiaries, that is, the exposure of the persons who became Medicare beneficiaries to the addictive properties of nicotine in the defendants' cigarettes, directly or indirectly resulted from the acts of the defendants.

75. The persons who became Medicare beneficiaries did not consent to this harmful or offensive contact, that is, they did not consent to exposure to the addictive properties of nicotine in the defendants' cigarettes.

76. This harmful or offensive contact constitutes a battery.

77. As a result of this battery, these persons who became Medicare beneficiaries contracted diseases attributable to smoking the defendants' cigarettes.

78. The defendants are liable for the medical expenses incurred to treat the diseases attributable to smoking the defendants' cigarettes of these persons who are the victims of the defendants' battery.

79. From the time the victims of the defendants' battery became Medicare beneficiaries, Medicare paid for the medical expenses necessitated by their diseases attributable to smoking the defendants' cigarettes.

CAUSE OF ACTION

80. Plaintiff repeats and realleges each and every allegation contained in paragraphs 1 through 79, as though filly set forth herein.

81. As a result of their battery, each defendant was and is an entity which has or had a responsibility to pay for the costs of the health care services provided to Medicare beneficiaries to treat their diseases attributable to smoking the defendants' cigarettes, within the meaning of the MSP statute.

82. Under the terms of the MSP statute, each defendant was and is, with respect to the costs of the health care services provided to Medicare beneficiaries to treat their diseases attributable to smoking the defendants' cigarettes, a primary plan and so required to be the payer primary for those costs, while Medicare was to be only the secondary payer.

83. None of the defendants paid for, or in any other way provided for primary payment of, these costs of the health care services provided to Medicare beneficiaries to treat their diseases attributable to smoking the defendants' cigarettes, in violation of the MSP statute.

84. Due to this wrongful conduct of the defendants, Medicare became and continues to be the primary payer for these costs of the health care services provided to Medicare beneficiaries to treat their diseases attributable to smoking the defendants' cigarettes, in violation of the MSP statute.

85. Under the terms of the MSP statute, Medicare's payments for these costs of the health care services provided to Medicare beneficiaries to treat their diseases attributable to smoking the defendants' cigarettes were conditioned on reimbursement from the correct primary payer, which each defendant is.

86. As a result, under the MSP statute, damages from the defendants should be awarded in an amount twice that of Medicare's payments for the costs of the health care services provided to Medicare beneficiaries to treat their diseases attributable to smoking the defendants' cigarettes.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff respectfully prays that the Court enter judgment against the defendants, and each of them, jointly and severally:

a. awarding the plaintiff damages in an amount double the amount paid by Medicare for the health care services provided to Medicare beneficiaries to treat their diseases attributable to smoking the defendants' cigarettes, for which treatment the defendants were "required or responsible . . . to make

payment" under the Medicare as Secondary Payer Act;

b. awarding the plaintiff attorneys' fees and the costs of this litigation, including interest; and

c. granting such other and further relief as the Court may deem just and proper.

JURY DEMAND

The Plaintiff hereby demands a jury on all counts so triable.

Respectfully submitted,

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In The

Supreme Court of the United States

UNITED SENIORS ASSOCIATION, INC.,
AS A PRIVATE ATTORNEY GENERAL,

Petitioner,

v.

PHILIP MORRIS USA, R.J. REYNOLDS TOBACCO COMPANY, BROWN & WILLIAMSON TOBACCO CORPORATION, INDIVIDUALLY AND AS THE SUCCESSOR TO THE AMERICAN TOBACCO COMPANY, LORILLARD TOBACCO COMPANY, AND LIGGETT GROUP, INC.,

Respondents.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The First Circuit

SUPPLEMENTAL BRIEF IN SUPPORT OF PETITION FOR A WRIT OF CERTIORARI

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SUPPLEMENTAL BRIEF IN SUPPORT OF PETITION FOR WRIT OF CERTIORARI

Pursuant to Rule 15.8 of this Court, Petitioner, United Seniors Association, Inc., respectfully submits this Supplemental Brief in support of its Petition for Writ of Certiorari filed on November 14, 2007 (the "Petition").

GROUNDS FOR FILING A SUPPLEMENTAL BRIEF

On November 27, 2007, thirteen days after our Petition was filed, the United States Court of Appeals for the Eighth Circuit filed its decision in *Stalley v. Catholic Health Initiatives*, No. 06-3884 (8th Cir. Nov. 27, 2007) (Supp.App. 1a-22a.). Our Petition advised the Court that over 50 cases, including *Stalley*, were pending in the lower federal courts raising the same issue presented in this case – whether the private right of action enacted to enforce the Medicare as Secondary Payer ("MSP") statute is a *qui tam* provision giving any person standing to sue on behalf of Medicare to recover its expenditures from the responsible primary payer. *See* Pet. 2. We noted that these cases were marching in lockstep with the First Circuit's analysis here, and that it was unlikely that another Circuit might hold differently. *Id.* 36. With the *Stalley* decision, another Circuit now has ruled and followed the First Circuit to conclude that the MSP private action is not a *qui tam* provision.

The *Stalley* opinion confirms the disarray of the lower courts concerning the meaning of the MSP's private action. It employs confused and contradictory analyses unanchored to the statutory text or this Court's precedents to hinder effective administration of a critical federal program. Moreover, *Stalley* is yet another example of the widespread litigation that is highly unlikely to further sharpen this issue for this Court's consideration, churning on while the taxpayers' Medicare dollars drain away to private insurers. Thus *Stalley* confirms the need for the Court to grant our Petition and resolve this issue.

As *Stalley* is a new case, not available at the time of our last filing, yet very relevant to the Court's consideration of our Petition, it is an appropriate subject for this Supplemental Brief under Rule 15.8. Additionally, Respondents have waived their right to file a brief in opposition, and so we cannot anticipate that we will have a reply brief by which to bring *Stalley* to the Court's attention.

ARGUMENT

Stalley is an MSP private action brought under 42 U.S.C. §1395y(b)(3)(A) to recover Medicare's expenditures for the medical care required by Medicare beneficiaries as a result of the alleged misconduct of the hospitals in which they were patients. Supp.App. 3a-5a. The Eighth Circuit affirmed dismissal of the case on the ground that the MSP private

action did not authorize a *qui tam* suit, and that the plaintiff otherwise had suffered no injury-in-fact to give him standing. *Id.* 3a.

To reach this conclusion, the Eighth Circuit reasoned that, since the statute created a "*private cause of action*," it did not create a *qui tam* action to "vindicate public rights." *Id.* 9a (emphasis in original). The court pointed to the dissimilarities between the MSP private action and the *qui tam* provisions of the False Claims Act ("FCA") as further support for this notion. *Id.* While the Eighth Circuit acknowledged "language in some circuit-level decisions indicating that the private plaintiff can assert the government's rights under §1395y(b)(3)(A)," it nevertheless concluded "that the statute actually allows a private plaintiff to assert his own rights, not those of the government." *Id.* 10a-11a (citing *Glover v. Liggett Group, Inc.*, 459 F.3d 1304, 1307 (11th Cir. 2006) and *Manning v. Utilities Mutual Ins. Co.*, 254 F.3d 387, 394 (2d Cir. 2001)).

The Eighth Circuit then addressed the key question: if an MSP private action is not a *qui tam*, then who *does* have standing to bring such a case? As the *Stalley* court admitted, if no one could bring an MSP private action, "that would be a powerful argument that such an interpretation [that it is not a *qui tam*] was wrong." Supp.App. 12a.[1] The court held that

[1] The Eighth Circuit pointed out that the *Stalley* appellees "decline[d]" to give an example of who could bring an MSP

(Continued on following page)

the MSP private action allows a Medicare beneficiary "to sue to vindicate his or her own contractual and tort interests." *Id.* 19a. In the Eighth Circuit's view, "Congress contemplated that Medicare beneficiaries could recover double damages to vindicate their private rights when their primary payers fail to live up to their obligations, even if Medicare has made a conditional payment of the beneficiaries' expenses." *Id.* 20a. While this reading relies on an injury to the Medicare beneficiary – which has no necessary relation to any Medicare expenditure – to provide standing, the court "anticipate[d] that a portion of the beneficiary's recovery would be paid to reimburse Medicare." *Id.* 21a.

Stalley underscores the radical departure of the lower federal courts from this Court's precedents governing standing in *qui tam* cases described in our Petition. Indeed, *Stalley* illustrates that, if anything, the lower courts' apparent analytical challenges in interpreting MSP only promise to become more acute, and threaten to confuse the most fundamental norms of statutory construction and standing to sue.

1. To find that the MSP private action is not a *qui tam* provision, the Eighth Circuit embraced the First Circuit's conclusion in this case that the

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private action to recover Medicare expenses if it is not a *qui tam* action, because they believed, contrary to the court's view, that they "need not even delve into this sort of speculation about the MSP statute's possible uses." Supp.App. 12a.

dissimilarity between the FCA and MSP indicates that the MSP private action is not a *qui tam* suit. *Id.* 9a (citing *United Seniors Ass'n v. Philip Morris USA*, 500 F.3d 19, 24-25 (1st Cir. 2007)). In so doing, the Eighth Circuit, like the First here, placed itself directly at odds with this Court's long-established precedents construing *qui tam* provisions. *See* Pet. 20-26.

In addition, the Eighth Circuit reasoned that, because the MSP refers to the private cause of action as just that, "a private cause of action," §1395y(b)(3)(A), it authorizes suits by individuals "*qua* individuals," not as private attorneys general. Supp.App. 9a. Yet fashioning such a dichotomy between "private" and "public" to conclude MSP does not create a *qui tam* action is at odds with both this Court's understanding of the nature of a *qui tam* action and the words Congress has used in the past to create them.

Contrary to *Stalley's* sharp divide between "private" and "public," our jurisprudence, lead by this Court's precedents, has long understood that the private *qui tam* plaintiff is a "person who mixes private and public features in the adjudicative arena." W. Rubenstein, *On What A "Private Attorney General" Is – And Why It Matters*, 57 VAND.L.REV. 2129, 2131 (2004). *See also* J. Gold, *Legal Duties That Qui Tam Relators and Their Counsel Owe to the Government*, 20 GEO.J.LEGAL ETHICS 629, 631 (2007) ("[T]he relator serves the public interest as well as his own pecuniary interest."). "A *qui tam* suit . . . involves a combination of two distinct interests; one of which

is public, the other private." Note, *The History and Development of Qui Tam*, 1972 WASH.U.L.Q. 81, 83. Thus, this Court has pointed out that the *qui tam* plaintiff is not simply an agent of the government, advancing solely the public interest, but has his own, distinctive private interest in the lawsuit. *Vermont Agency of Natural Resources v. United States ex rel. Stevens*, 529 U.S. 765, 772 (2000).

Reflecting this dual character of *qui tam*, Congress has used variations of the phrase "private cause of action" without hesitation to create *qui tam* actions. The FCA itself titles its *qui tam* as "Actions by private persons." 31 U.S.C. §3730(b). Accordingly, the FCA "grant[s] any private 'person' the right to bring a civil action under the Act." *United States ex rel. Williams v. NEC Corp.*, 931 F.2d 1493, 1498 (11th Cir. 1991). *See also, e.g.*, 17 U.S.C. §1326(b) (*qui tam* suit to recover penalty for false marking titled "Suit by private persons").

Beyond the fact that the simple use of "private cause of action" cannot have the significance with which the Eighth Circuit invested it, the MSP itself, in the same sentence in which the phrase appears, describes what this private action is for. It is an action "for damages . . . in the case of a primary plan which fails to provide for primary payment (or appropriate reimbursement) in accordance with paragraphs (1) and (2)(A) [the basic secondary-payer rules]." §1395y(b)(3)(A). Congress gave no other role to this action. It created a private action with the sole purpose of recovering Medicare dollars, that is, to

remedy "an economic wrong done to the government." *Manning*, 254 F.3d at 394. In the MSP private action, Congress created a classic *qui tam* to authorize private actions to recover government money. The Eighth Circuit's narrow reading of the text achieves a result clearly at odds with the congressional design, like that of the First Circuit here. *See* Pet. 20-21.

Stalley holds that the MSP private action does not allow a private person to "vindicate public rights," Supp.App. 9a, and that an MSP private plaintiff is allowed only "to assert his own rights, not those of the government," *id.* 11a, yet strains to squeeze some secondary benefit to Medicare out of this wholly private affair with its "anticipation that a portion of the beneficiary's recovery would be paid to reimburse Medicare." *Id.* 21a. Besides failing to point to any support for this notion that Congress chose such an oblique and uncertain route to recover Medicare money instead of following the familiar *qui tam* path, the *Stalley* court fails to explain why Congress needed to enact the MSP private action at all if it was designed as *Stalley* contends. Medicare beneficiaries already have state causes of action to vindicate their private claims. In a tort action, the plaintiff would recover the medical expenses caused by the tort, including those paid by Medicare. *See* RESTATEMENT (SECOND) OF TORTS §920A(2). Medicare could then recover its money from the prevailing beneficiary. *See* §1395y(b)(2)(B)(iii); 42 C.F.R. §§411.22(a), 411.24(g). Thus existing state law and MSP without the private

action does precisely what *Stalley* says Congress added the private action to do.

2. To avoid a straightforward reading of MSP, *Stalley* cites three state cases as the model Congress supposedly used to write the private action – an action, according to the Eighth Circuit, by which "a Medicare beneficiary could sue his private insurer and recover his expenses incurred, even if those expenses had already been paid by Medicare." Supp.App. 18a. But in each of these cases, both Medicare and a private insurer had paid their shares of a Medicare beneficiary's expenses; there was no claim of improper conduct by the private insurer. Rather, the question in each case was whether the terms of the private insurance contract required the insurer to pay the beneficiary all the medical expenses incurred, including those paid for by Medicare. The plaintiff was suing for an amount equivalent to Medicare's expenditure to keep for itself, not to return to Medicare. *See Holmes v. California State Automobile Ass'n*, 135 Cal.App.3d 635 (Cal.Ct.App. 1982); *Black v. American Bankers Ins. Co.*, 478 S.W.2d 434 (Tex. 1972); *Niles v. American Bankers Ins. Co.*, 229 So.2d 435 (La.Ct.App. 1969).

In these cases, the plaintiff's injury-in-fact arose from a contract right, and that injury-in-fact was not used to justify standing to remedy a different injury to a third party, which is the gloss *Stalley* has put on the MSP private action. Moreover, in the context of a Medicare beneficiary injured by a tort, the MSP defendant is not the beneficiary's insurer, but the

liability insurer of the tortfeasor (or the tortfeasor itself if self-insured). *See* 54 Fed.Reg. 41,716, 41,727 (Oct. 11, 1989) ("Liability insurance . . . is a contractual arrangement between a policyholder (i.e. the tortfeasor) and an insurer."). Where a liability insurer is the primary payer, an MSP action could never be premised on a contract right *of a Medicare beneficiary*. Thus *Stalley's* interpretation would leave a major part of MSP beyond the reach of the MSP private action, a judicially fashioned barrier to MSP enforcement finding no basis in the statute, its legislative history, or the purpose of the MSP regime.

3. *Stalley's* most egregious departure from this Court's precedents and MSP's text is its holding that a Medicare beneficiary has standing to bring an MSP private action to remedy Medicare's economic injury based on the quite different personal injury to that Medicare beneficiary. Supp.App. 18a-19a. This is pure judicial invention. *Stalley* points to nothing in the statute that even comes close to saying this.

This contrivance runs directly contrary to this Court's most well-established precedents governing standing. "The Art. III judicial power exists only to redress or otherwise to protect against injury *to the complaining party*." *Warth v. Seldin*, 422 U.S. 490, 499 (1975) (emphasis added). Such "buddy-breathing" on an injury suffered by a beneficiary to provide standing to remedy Medicare's different injury simply cannot pass constitutional muster, even recognizing the power of Congress to establish causes of action:

> Congress has the power to define injuries and articulate chains of causation that will give rise to a case or controversy where none existed before. . . . In exercising this power, however, Congress must at the very least identify the injury it seeks to vindicate and relate the injury to the class of persons entitled to bring suit.
>
> . . .
>
> While it does not matter how many persons have been injured by the challenged action, *the party bringing suit must show that the action injures him in a concrete and personal way.*

Lujan v. Defenders of Wildlife, 504 U.S. 555, 580-81 (1992) (Kennedy, J., concurring in part and concurring in the judgment) (emphasis added). *See also United States ex rel. Milam v. University of Texas M.D. Anderson Cancer Center*, 961 F.2d 46, 49 (4th Cir. 1992) ("The government, and not the relator, must have suffered the 'injury-in-fact' required for Article III standing.").

The sole cognizable injury-in-fact that can establish standing to enforce MSP, whether by the government or a private party, is the economic injury to Medicare caused by it paying a medical expense that is the responsibility of another insurer. Contrary to *Stalley* and the First Circuit here, a Medicare beneficiary can never, by definition, suffer this injury. Indeed, as to the costs paid by Medicare, the beneficiary suffers no injury of any kind. The only way a

statute authorizing a "private cause of action" to recover Medicare's money can be constitutional is by following the path set out in *Vermont Agency* – the statute must effect a partial assignment of Medicare's claim. 529 U.S. at 773. This, the MSP private action does. Nothing in the statute compels a contrary reading that would leave that provision a nullity.

4. *Stalley* also illustrates the analytical churning in the lower courts concerning MSP that has reached such a level that courts apparently sharing a hostility to MSP are advancing mutually contradictory explanations to defeat MSP enforcement. For example, the district court in this case adopted the policy-driven reasoning of the Eleventh Circuit in *Glover* to hold that a responsibility to pay Medicare must be established before an MSP action can be brought. *See* Pet. 18a. (The First Circuit affirmed dismissal solely on standing.) The district court (and the Eleventh Circuit) was concerned that the MSP action would disrupt "the allocation of jurisdiction between federal and state courts . . . 'by creating a federal forum to litigate any state tort claim in which a business entity allegedly injured a Medicare beneficiary.'" Pet.App. 26a-27a (quoting *Glover*, 459 F.3d at 1309). Yet the Eighth Circuit in *Stalley* – in order to claim some use for the MSP private action if it is not a *qui tam* – holds that this is precisely what Congress did – it "federalized" state torts to allow a Medicare beneficiary's private injury-in-fact to be used to remedy a distinct injury to Medicare.

Such contradictions manifest judicial decision-making that can only confuse congressional law-writing, agency administration of a major federal program, and legal advocacy. This Court's resolution of the question of standing under the MSP private action is sorely needed.

CONCLUSION

For the foregoing reasons and those set out in our Petition, this Court should issue a writ of certiorari to review the decision of the First Circuit.

Respectfully submitted,

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December 4, 2007

United States Court of Appeals
FOR THE EIGHTH CIRCUIT

No. 06-3884

Douglas B. Stalley, on behalf of the United States of America,

Plaintiff/Appellant,

v.

Catholic Health Initiatives, a Colorado Corporation; Bergen Mercy Foundation, Inc., a Nebraska corporation; Alegent Health-Bergen Mercy Health System, a Nebraska corporation; Alegent Health, a Nebraska corporation; Preferred Professional Insurance Company, a Nebraska corporation; Advocate Insurance Resources SPC, a Cayman Islands company,

Defendants/Appellees.

No. 06-4121

Appeals from the United States District Court for the Eastern District of Arkansas.

Douglas B. Stalley, on behalf of the United States of America,

Plaintiff/Appellant,

v.

Triad Hospitals, LLC, a Delaware limited liability company; Triad Hospitals, Inc., a Delaware Corporation; Triad Hospitals Holdings, Inc., a Delaware corporation; Parthenor Insurance Company, Limited, a Bermuda company; Health Midwest Insurance Company, Limited, a Cayman Islands company; Health Care Indemnity, Inc., a Colorado corporation,

Defendants/Appellees.

Submitted: May 17, 2007
Filed: November 27, 2007

Before WOLLMAN, BRIGHT, and JOHN R. GIBSON, Circuit Judges.

JOHN R. GIBSON, Circuit Judge.

In these two consolidated appeals we consider whether a plaintiff who has alleged no injury to himself has standing to bring suit under the Medicare Secondary Payer statute, 42 U.S.C. § 1395y(b)(3)(A). Because we conclude that the suit authorized by the statute is a private cause of action, which requires the plaintiff to have standing in his own right, rather than a *qui tam* statute, which allows the plaintiff to assert injury to the United States, we affirm the district courts'[1] dismissal of these cases.

Both of these cases were filed by the same plaintiff, Douglas B. Stalley, who has also filed many similar cases around the country.[2] Stalley alleges that the defendants Catholic Health Initiatives[3] and Triad Hospitals, Inc.[4] are medical care providers

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[1] The district judge in *Stalley v. Catholic Health Initiatives*, No. 06-3884, was the late Honorable George Howard, Jr., United States District Judge for the Eastern District of Arkansas. The district judge in *Stalley v. Triad Hospitals*, No. 06-4121, was the Honorable William R. Wilson, United States District Judge for the Eastern District of Arkansas.

[2] Erin Brockovich has filed a number of similar cases in California.

[3] Stalley also lists Bergen Mercy Foundation, Inc., Alegent Health-Bergen Mercy Health System, Alegent Health as provider plaintiffs, but refers to these together with Catholic Health Initiatives as "CHI."

[4] Stalley also lists Triad Hospitals LLC and Triad Hospital Holdings, Inc. as provider plaintiffs, but refers to these defendants together with Triad Hospitals, Inc. as "Triad."

participating in the Medicare program, who partly self-insure for malpractice. He alleges that the insurance company defendants[5] were subsidiaries or sister companies to the provider defendants and wrote malpractice insurance for the provider defendants.

Stalley's substantive allegations are substantially the same in the two suits before us:

> On numerous occasions, [the provider defendants] by and through [their] employees and agents, caused harm to Medicare recipients who were patients in [the defendants'] hospitals, thereby triggering legal obligation on the part of [the hospital defendants] and the other primary payer Defendants herein to pay for any consequential medical service, treatment, or medication. Nevertheless, [the provider defendants] provided medical services, treatment, and medication to such Medicare recipients who were harmed by [the provider defendants'] own conduct, and thereafter received reimbursement from Medicare for treating those injured Medicare recipients.

The complaints allege that the insurer defendants knew that the provider defendants had injured the

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[5] In the Catholic Health Initiatives case, the insurer defendants are Preferred Professional Insurance Company and Advocate Insurance Resources, SPC. In the Triad case, the insurer defendants are Parthenon Insurance Company, Limited, Health Midwest Insurance Company, Limited, and Health Care Indemnity, Inc.

Medicare beneficiaries and that the insurer defendants were liable as primary payers, yet the insurer defendants did not reimburse Medicare for the costs of treatment. The complaint does not allege that Stalley was either a Medicare beneficiary or a patient of the defendants or that he was injured by the defendants in any way. For that matter, the complaint does not identify any particular person who was injured by the defendants at any particular time.

The defendants in both cases moved to dismiss for lack of jurisdiction and for failure to state a claim. Both district courts granted the motion. The district court in the *Catholic Health Initiatives* case ruled first, holding that Stalley lacked constitutional standing to bring the suit because he had not alleged any injury to himself. *Stalley v. Catholic Health Initiatives,* 458 F. Supp. 2d 958, 962-63 (E.D. Ark. 2006). Stalley contended that he had standing because he asserted injury to the United States and the Medicare Secondary Payer statute was a *qui tam* statute that authorized him to bring suit as relator for the United States. The district court examined the Medicare Secondary Payer statute and found no support for the notion that it was a *qui tam* statute. *Id.* at 963. Accordingly, the court dismissed Stalley's suit under Fed. R. Civ. P. 12(b)(1) for lack of standing. Alternatively, the court held that Stalley had not alleged a cause of action under 42 U.S.C. § 1395y(b)(3)(A) because he had not alleged that the provider defendants' liability had been "demonstrated," and the duty of the primary insurer to pay or to reimburse

Medicare did not arise until the tortfeasor's liability has been "demonstrated" by judgment or other comparable means. *Id.* at 964 (relying on *Glover v. Liggett Group, Inc.*, 459 F.3d 1304, 1309 (11th Cir. 2006)). The district court in *Triad* relied on Judge Howard's conclusion in *Catholic Health Initiatives* that § 1395y(b)(3)(A) is not a *qui tam* statute and that Stalley therefore lacked standing to sue.[6]

The standard of review of a district court's decision under Fed. R. Civ. P. 12(b)(1) depends on whether the district court resolved a facial attack or a factual attack on subject matter jurisdiction. *Osborn v. United States*, 918 F.2d 724, 729 n. 6 (8th Cir. 1990). If, as here, the district court addressed a deficiency in the pleadings, our standard of review is the same standard we apply in Rule 12(b)(6) cases. *Mattes v. ABC Plastics, Inc.*, 323 F.3d 695, 697-98 (8th Cir. 2003). We accept as true all factual allegations in the complaint, giving no effect to conclusory allegations of law. *Id.* at 698. The plaintiff must assert facts that affirmatively and plausibly suggest that the

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[6] An incomplete list of other district court cases dismissing Stalley's or Brockovich's § 1395y(b)(3)(A) claims for lack of standing includes *Stalley v. Orlando Regional Healthcare Systems, Inc.*, No. 06-1824 (M.D. Fla. Jan. 22, 2007); *Stalley v. Methodist Healthcare*, No. 06-2605 (W.D. Tenn. Dec. 22, 2006); *Brockovich v. Loma Linda University Medical Center*, No. 06-0834 (C.D. Cal. Nov. 15, 2006); *Brockovich v. Healthplus Corp.*, No. 06-5660 (C.D. Cal. Nov. 15, 2006); *Brockovich v. Scripps Health*, No. 06-1569 (S.D. Cal. Nov. 7, 2006). The defendants advise us that no court has held that Stalley or Brockovich have standing to assert these claims.

pleader has the right he claims (here, the right to jurisdiction), rather than facts that are merely consistent with such a right. *See Bell Atl. Corp. v. Twombly*, 127 S. Ct. 1955, 1964-66 (2007).

The party invoking federal jurisdiction has the burden of establishing that he has standing to assert the claim. *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 561 (1992). Standing consists of three elements: the plaintiff must have suffered an injury in fact; there must be a causal connection between that injury and the conduct complained of; and it must be likely that the injury would be redressed by a remedy the court could order. *Id.* at 560-61. "At the pleading stage, general factual allegations of injury resulting from the defendant's conduct may suffice, for on a motion to dismiss we presume that general allegations embrace those specific facts that are necessary to support the claim." *Id.* at 561 (internal quotation marks omitted).

Stalley does not contend that he himself has sustained any injury in fact. Instead, he contends that the Medicare Secondary Payer statute is a *qui tam*[7] statute. A *qui tam* statute effectively assigns part of the government's interest to a relator so that the relator has standing to assert an injury suffered

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[7] "*Qui tam* is short for the Latin phrase *qui tam pro domino rege quam pro se ipso in hac parte sequitur*, which means 'who pursues this action on our Lord the King's behalf as well as his own.'" *Vt. Agency of Nat. Res. v. United States ex rel. Stevens*, 529 U.S. 765, 768 n. 1 (2000).

by the government. *See Vt. Agency of Nat. Res. v. United States ex rel. Stevens,* 529 U.S. 765, 772-74 (2000). ("The [False Claims Act] can reasonably be regarded as effecting a partial assignment of the Government's damages claim. . . . We conclude, therefore, that the United States' injury in fact suffices to confer standing on respondent Stevens.") *Qui tam* actions developed around the end of the thirteenth century as a way for individuals who had suffered harm to avail themselves of the royal courts by pleading a harm to the King as well as to themselves. *Id.* at 774-75. Well before American independence, the action evolved into the modern form in which informers who had not suffered harm personally, but who knew of harm done to the government, were authorized by statute to sue the wrongdoer on the government's behalf and to retain a portion of the damages awarded the government as a "bounty" or reward for bringing the wrongdoing to light. *Id.* at 775-77. "There presently is no common-law right to bring a *qui tam* action, which is strictly a creature of statute." *United Seniors Ass'n v. Philip Morris USA,* 500 F.3d 19, 23 (1st Cir. 2007); *accord United States ex rel. Burnette v. Driving Hawk,* 587 F.2d 23, 24 (8th Cir. 1978). The best known *qui tam* statute today is the False Claims Act, 31 U.S.C. §§ 3729-3732, which conferred standing on the plaintiff in *Vermont Agency of Natural Resources,* 529 U.S. at 778.

The plain language of § 1395y(b)(3)(A) says, "There is established a *private cause of action* for damages . . . " (emphasis added). A "private" right is

different from a public right, *see Black's Law Dictionary*, "Right" (8th ed. 2004) (private right is defined as "A personal right, as opposed to a right of the public or the state."), and *qui tam* cases exist to vindicate public rights. Thus, the Medicare Secondary Payer statute purports to give a substantive right to individuals *qua* individuals, not as private attorneys general or assignees of a public right. In contrast, the False Claims Act *qui tam* provision authorizes a private person to bring a civil action "for the person and for the United States Government. The action shall be brought in the name of the Government." 31 U.S.C. § 3730(b). Moreover, the Medicare Secondary Payer statute lacks any provisions giving the government the right to control the action, such as the right to dismiss the action, the right to veto a dismissal or settlement, and the right to review the complaint *in camera* before the relator serves the complaint on the defendant. Again, in contrast, the False Claims Act has extensive provisions giving the government these rights and more. *See* 31 U.S.C. § 3730. The absence of procedural safeguards giving the executive branch control over the prosecution of the action and the proceeds is powerful evidence that Congress did not mean § 1395y(b)(3)(A) to function as a *qui tam* statute. *See United Seniors Ass'n*, 500 F.3d at 24-25 (affirming dismissal for lack of standing of Medicare Secondary Payer private action by plaintiff who had no personal injury); *In re Guidant Corp. Implantable Defibrillators Prods. Liability Lit.*, 484 F. Supp. 2d 973, 980-81 (D. Minn. 2007) (dismissing Medicare Secondary Payer private action for lack

of standing), *reconsidered on different grounds,* 2007 WL 2028137 (D. Minn. May 9, 2007).

Stalley relies on a statement in *Mason v. American Tobacco Co.,* 212 F.Supp.2d 88, 94 (E.D.N.Y. 2002), *aff'd*, 346 F.3d 36 (2d Cir. 2003), that the private right of action provided by § 1395y(b)(3)(A) is "similar to a *qui tam* action where anyone can bring a claim on behalf of the United States government and receive a bounty." *See also Manning v. Utils. Mut. Ins. Co.,* 254 F.3d 387, 394 (2d Cir. 2001) (referring to the Medicare Secondary Payer statute as creating "private attorneys general"). The aspects of the Medicare Secondary Payer statute that are similar to a *qui tam* provision are that (1) it is based on the informer principle, in which the government relies on private persons with superior knowledge to discover the government's claim; (2) it increases the damages payable in order to motivate a private party to take action; and (3) the government expects to recoup part of the private party's recovery. In *Manning,* the Second Circuit relied on these kinds of similarities to conclude that the False Claims Act provided the most analogous statute of limitations to apply to § 1395y(b)(3)(A) claims. 254 F.3d at 394.

Even though the private right of action under § 1395y(b)(3)(A) shares these characteristics of a *qui tam* statute, it may not be a *qui tam* statute if Congress intended the plaintiff to act as a private plaintiff, asserting his own injury, rather than as a relator, asserting the government's injury. Despite language in some circuit-level decisions indicating that the

private plaintiff can assert the government's rights under § 1395y(b)(3)(A), *Glover v. Liggett Group, Inc.*, 459 F.3d 1304, 1307 (11th Cir. 2006) ("The MSP also creates a private right of action with double recovery to encourage private parties who are aware of non-payment by primary plans to bring actions *to enforce Medicare's rights.*") (emphasis added); *Manning,* 254 F.3d at 394 (stating that Medicare Secondary Payer statute allows individual citizens "to sue in order to right an economic wrong done to the government"), we conclude that the statute actually allows a private plaintiff to assert his own rights, not those of the government. *See Frazer v. CNA Ins. Co.,* 374 F. Supp. 2d 1067, 1083 (N.D. Ala. 2005) ("[T]he MSPA does not create a cause of action which would permit a non-Medicare eligible worker's compensation claimant to bring such an action . . . ").

Stalley argues that the statute cannot be read to contemplate that only a private party who was actually injured can assert the private right of action. Stalley argues that such a reading is impossible because no private plaintiff would ever have an injury which would both (1) be a cognizable injury for which the plaintiff could recover and (2) lead to a recovery which the government could recoup. Thus, Stalley says that the only way the "private right of action" can help the government recoup money from primary payers is if it functions as a *qui tam* statute empowering a private person to assert the government's rights, rather than his own rights. Therefore, according to Stalley, a volunteer like himself, who has no

relationship with the primary payer and has suffered no injury, can sue under the private right of action and recover double damages for the injury to the government. Catholic Health Initiatives' brief declines to identify a case in which the private right of action would be enforceable by an individual and lead to recoupment of Medicare expenses by the government; Catholic Health Initiatives tells us that we "need not even delve into this sort of speculation about the MSP statute's possible uses," but if there were truly no way that the private right of action would ever have any effect under Catholic Health Initiatives' interpretation, that would be a powerful argument that such an interpretation was wrong. To understand whether Stalley's argument is correct, we have to determine how the Medicare Secondary Payer statute as a whole was meant to work and how the private right of action fits within that framework.

Medicare is a federal program that provides health insurance for the elderly, the disabled, and renal patients. *Blue Cross & Blue Shield of Tex., Inc. v. Shalala*, 995 F.2d 70, 71 (5th Cir. 1993). In order to control the cost of Medicare, in 1980 Congress passed the Medicare Secondary Payer statute, 42 U.S.C. § 1395y(b), which provides generally that Medicare insurance is secondary to employer-provided group health insurance covering Medicare beneficiaries and that Medicare will not be liable for expenses which the private insurer ought to pay. *See* 1395y(b)(2). The statute provides that the private insurers cannot draw their policies to make an end run around the

statute by excluding expenses that would be covered by Medicare if the person did not have group health insurance. § 1395y(b)(1). In addition to expenses covered by group health insurance, the statute also disclaims liability for expenses that should be paid under a workmen's compensation plan or under an automobile, liability, or no fault insurance policy, including a self-insurance plan. § 1395y(b)(2)(A). *See generally* Harvey L. McCormick, *Medicare and Medicaid Claims and Procedures* § 1:67 (Aug. 2007). Even though Medicare is not ultimately liable for these excluded expenses, the statute permits Medicare to pay those expenses up front, conditionally, and to require the liable insurer or other primary payer to reimburse Medicare for the moneys advanced. § 1395y(b)(2)(B)(i). The statute authorizes the government to sue any primary payer that has failed to reimburse Medicare for such conditional payments, and to collect double damages in such a suit. § 1395y(b)(2)(B)(iii). The government can also sue anyone that received payment from the primary payer with respect to expenses covered under Medicare, including the beneficiary himself, should he collect the payment but fail to reimburse the government. *Id.*; 42 C.F.R. § 411.24(g) (government has right of action against beneficiary that has received primary payment); *United States v. Sosnowski,* 822 F. Supp. 570, 574 (W.D. Wis. 1993) (granting government recovery from beneficiary from settlement with primary payer). The statute provides that the United States is subrogated to the rights of the Medicare beneficiaries against their insurer, to the extent of

Medicare payments the government has made for the beneficiaries' expenses. § 1395y(b)(2)(B)(iv).

Congress added a private right of action to the Medicare Secondary Payer statute in 1986. Pub. L. No. 99-509, § 9319, 100 Stat. 1874 (1986) (codified as amended at 42 U.S.C. § 1395y(b)(3)(A)). Section 1395y(b)(3)(A) grants the Medicare beneficiary a private right of action for double damages against an insurer or other primary payer that fails to pay the amounts it owes on the insured's behalf. The parties do not point us to any legislative history explaining the purpose of the private right of action, nor have we found any legislative history directly explaining how the private right was meant to work. *See* H.R. Conf. Rpt. No. 99-1012, at 321 (1986), *reprinted in* 1986 U.S.C.C.A.N. 3868, 3966 (merely stating that the private right of action is "to enforce the provision for the aged"); S. Rpt. No. 99-348, at 140 (1986) (stating that obligation of primary payers "would be enforceable by private action or by the Federal Government"). Courts considering the provision have generally agreed that the apparent purpose of the statute is to help the government recover conditional payments from insurers or other primary payers. *See, e.g., United Seniors*, 500 F.3d at 21-22 ("To facilitate recovery of these conditional payments, the MSP . . . (iii) creates a private cause of action with double recovery to encourage private parties to bring actions to enforce Medicare's rights.") (citation omitted); *Manning*, 254 F.3d at 396-97 & n. 8 ("The history of the MSP legislation is consistent with our view that

the private right of action was created to save money for the Medicare system."); *Frazer*, 374 F. Supp. 2d at 1077 ("The legislation's incentive to bring a private lawsuit is clearly based in turn upon the subrogation right of the government to obtain a portion of the recovery. The recovery of costs by Medicare is the primary purpose of the MSP."); *see also Harris Corp. v. Humana Health Ins. Co.*, 253 F.3d 598, 606 (11th Cir. 2001) (per curiam) ("A private cause of action for double damages . . . serves Congress' interest in the fiscal integrity of the Medicare program by deterring private insurers primary to Medicare under the statute from attempting to lay medical costs at the government's doorstep."). This is consistent with inclusion of the provision in The Omnibus Budget Reconciliation Act of 1986, which was intended to reduce government spending. *See* Statement by President of the United States, 22 Weekly Compilation of Presidential Documents 1421 (Oct. 27, 1986), *reprinted in* 1986 U.S.C.C.A.N. 4073-74. Additionally, as the Second Circuit pointed out in *Manning,* 254 F.3d at 397 n. 8, when Senator David Durenburger introduced the President's Medicare proposals for 1986, which included the private right of action, he referred to the proposals as "health care cost reduction proposals." 132 Cong. Rec. 21935 (Aug. 15, 1986).

The thinking behind the statute is apparently that (1) the beneficiary can be expected to be more aware than the government of whether other entities may be responsible to pay his expenses; (2) without the double damages, the beneficiary might not be

motivated to take arms against a recalcitrant insurer because Medicare may have already paid the expenses and the beneficiary would have nothing to gain by pursuing the primary payer; and (3) with the private right of action and the double damages, the beneficiary can pay back the government for its outlay and still have money left over to reward him for his efforts.

Stalley contends that the statute has to be a *qui tam* statute because under the payment procedures outlined by the statute, Medicare will pay the beneficiary's expenses when the primary insurer fails to pay, and as a result, the Medicare beneficiary will not have been injured by the primary payer's failure to pay and cannot recover anything in his own right. Stalley argues that if the Medicare beneficiary has not been injured, Congress must have intended the private right of action to allow the private plaintiff to sue on behalf of the government, the only injured party. Under Stalley's reasoning, the private right of action is merely an assignment of the government's public right.

We reject the assertion that a Medicare beneficiary could never have an injury of his or her own to vindicate by means of the private right of action. There are two scenarios in which a private plaintiff conceivably could bring suit under the Medicare Secondary Payer statute: either the insurer failed to pay and the government has not paid, or else the insurer failed to pay and the government did pay. In the first case, the plaintiff was obviously injured by

the insurer's failure to pay, but the government has not yet paid any money. This would not appear to be the factual situation which the statute was created to remedy, because in this case, the government would have nothing to recover and therefore would not benefit from the services of the informer/plaintiff. If the first situation were the only one in which the beneficiary could sue, the private right of action would not save the government money. Moreover, in this first factual situation, there would be no need for the double damages incentive; if the government had not paid the expenses, the beneficiary would have an incentive to sue the primary payer even without double damages, to avoid having to pay the expenses him or herself.

In the second case, in which the primary payer failed to pay and the government has paid the expense, has the Medicare beneficiary been injured by the primary payer's failure to pay something the government paid anyway? Triad Hospitals and related defendants argue that a beneficiary whose primary payer refused to pay would have damages even if Medicare paid the beneficiary's expenses because the beneficiary would have to pay Medicare co-payments and deductibles. But as Stalley points out, if those were the beneficiary's only damages, the beneficiary could only recover those amounts, not the amount that Medicare paid on its behalf. The co-payments and the deductible would be costs that are not covered by Medicare, so Medicare would not be entitled to recover those costs from the beneficiary.

Thus, Stalley argues, if the Medicare beneficiary can only recover expenses not paid by Medicare, the private right of action would not help the government recoup anything and it would be completely ineffectual as an aid to Medicare's recovery efforts; this compels the conclusion, he says, that the private plaintiff must be able to assert the government's rights directly, because there is no way the plaintiff's assertion of its own rights would help the government collect any money.

We conclude that Stalley's reasoning is flawed. Congress must have intended that a Medicare beneficiary could sue its primary insurer for expenses Medicare had already paid. There was authority extant in several states when Congress enacted the private right of action in 1986 that a Medicare beneficiary could sue his private insurer and recover his expenses incurred, even if those expenses had already been paid by Medicare. *See Holmes v. Cal. State Auto. Ass'n,* 185 Cal. Rptr. 521, 524 (Cal. Ct. App. 1982); *Black v. Am. Bankers Ins. Co.,* 478 S.W.2d 434 (Tex. 1972); *Niles v. Am. Bankers Ins. Co.,* 229 So.2d 435 (La. Ct. App. 1969). To be sure, there was also authority reaching the opposite conclusion, *e.g., Steffen v. Pac. Mut. Life Ins. Co.,* 442 S.W.2d 142, 144-45 (Mo. Ct. App. 1969) (policy was "not a policy of insurance in the usual sense but one of indemnity," meaning that insurer only agreed to reimburse insured for amounts insured was actually required to pay), but Congress could rationally have expected beneficiaries to be able to recover from their primary payers even if

Medicare has made a conditional payment. Moreover, some courts have interpreted the § 1395y(b)(3)(A) private right of action to authorize a Medicare beneficiary's recovery of expenses that have already been paid conditionally by Medicare. *Manning v. Util. Mut. Ins. Co.*, 254 F.3d 387, 391-92 (2d Cir. 2001) ("To encourage compliance with [the primary payment] requirements, Congress has authorized a private cause of action and double damages against entities designated as primary payers that fail to pay for medical costs for which they were responsible, which are borne in fact by Medicare."); *O'Connor v. Mayor & City of Baltimore*, 494 F. Supp. 2d 372, 374 (D. Md. 2007) (plaintiff had standing under § 1395y(b)(3)(A) because he averred that he had suffered injury for which City owed but failed to pay worker's compensation and Medicare had been forced to pay his expenses); *Collins v. Allstate Indem. Co.*, 626 A.2d 1162, 1166-67 (Pa. Super. Ct. 1993) (Medicare beneficiary had standing because "the plaintiffs allege a contractual right to the benefits owed, regardless of any independent claim to those benefits asserted by the United States."), *aff'd*, 660 A.2d 50 (Pa. 1995). The idea that Congress expected the beneficiary to be able to sue to vindicate his or her own contractual and tort interests is bolstered by the fact that the beneficiary's expenses will have only been paid "conditionally" by Medicare, § 1395y(b)(2)(B)(i), which leaves the beneficiary with less than a final settlement of his or her liability to the health-care providers.

On the other hand, the Third Circuit in *Wheeler v. Travelers Ins. Co.*, 22 F.3d 534, 538-39 (3d Cir. 1994), dismissed for lack of standing a Medicare beneficiary's suit against her primary insurer because her expenses had been paid by Medicare. Similarly, in *In re Guidant Corp.*, 484 F. Supp. 2d at 979-80, the plaintiff was a Medicare beneficiary allegedly harmed by the defendant's tort; she sued under § 1395y(b)(3)(A), but she conceded that she had no injury in fact from the alleged tortfeasor's failure to pay for her medical treatment because Medicare in fact paid for the treatment. The court dismissed her claim against the alleged tortfeasor for lack of standing because the Medicare beneficiary was not injured in light of the fact that her expenses were paid. *Id.* at 980-81. *Wheeler* was distinguished in *Brooks v. Blue Cross & Blue Shield,* No. 95-405, reproduced as appendix at 116 F.3d 1365, 1377 (S.D. Fla. 1995), *aff'd on other grounds,* 116 F.3d 1364 (11th Cir. 1997), because *Wheeler* was brought under state insurance laws and not under the Medicare Secondary Payer statute.

Our study of the Medicare Secondary Payer statute convinces us that Congress contemplated that Medicare beneficiaries could recover double damages to vindicate their private rights when their primary payers fail to live up to their obligations, even if Medicare has made a conditional payment of the beneficiaries' expenses. Therefore, there is no need to read the statute as permitting a plaintiff to assert the public's rights in contravention of the plain language

creating a private right of action. Moreover, if the private right of action statute were read as assigning the government's claim against a primary payer to a volunteer, if the beneficiary retained his or her tort or contract rights against the primary payer, the primary payer would effectively be liable for treble damages, not double; nothing in the statute or legislative history indicates Congress foresaw this extremely punitive result. Accordingly, we reject Stalley's argument that Congress created the private right of action to permit private persons to assert the government's rights, rather than their own, for we conclude that Congress rationally could have intended § 1395y(b)(3)(A) to provide Medicare beneficiaries a cause of action against their defaulting primary payers, with the anticipation that a portion of the beneficiary's recovery would be paid to reimburse Medicare.

With the demise of his principal argument, Stalley's case quickly crumbles. Stalley relies on the regulations that require a beneficiary whose expenses have been paid by Medicare and who then receives a payment from a primary payer to reimburse Medicare. 42 C.F.R. §§ 411.20 & 411.37. He contends that these regulations indicate the statute is a *qui tam* statute since they show that the proceeds will be split between the plaintiff and the government. Far from showing that the proceeds result from the plaintiff asserting the government's rights, the regulations are consistent with the idea that the Medicare beneficiary asserts his or her rights against the primary

payer and the government then asserts its own rights against the beneficiary, see § 1395y(b)(2)(B)(iii).

In sum, the private right of action provided by 42 U.S.C. § 1395y(b)(3)(A) is not a *qui tam* statute, and Stalley, who is a volunteer and who lacks any injury in fact, does not have standing to pursue such an action.

Stalley contends that the district court should have allowed him to replead, but in view of the fact that he has not indicated any amendment he could make that would cure the defect in his complaint, the district court correctly denied permission to replead as futile.

Stalley's motion to strike the Appellees' appendices in No. 06-4121 is denied.

We affirm the district courts' dismissal of the complaints.